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Cover photo by Terry Vine

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If you would like to submit a photograph for The Big Picture, please send it to Laura J. Albrecht, Photo Editor, *Texas Medicine*, 401 W 15th St, Austin, TX 78701.

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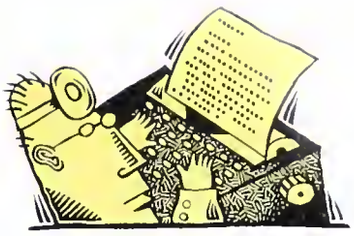

Letters

Getting the numbers right

In the October 1998 issue of *Texas Medicine,* Laurie Stoneham authored "Medical School Money" (pp 42–45). In the discussion and data included, Texas A&M University Health Science Center was mentioned, and its relation to Scott & White was alluded to but not defined.

The Texas A&M University Health Science Center was created through the Teague-Cranston legislation involving a partnership of the Central Texas Veterans Health Care System, Scott & White Hospital and Clinics, and Texas A&M University. This partnership has been quite productive and responsive to the needs of Texans.

The method of recording data, financial and otherwise, has presented some very complex problems for our health science center. As a result of the reporting requirements for state agencies, information from Scott & White and the Veterans Administration is rarely, if ever, included in the Texas A&M University Health Science Center reports.

We, in collaboration with the Association of American Medical Colleges, have developed a formula for dealing with this. During our most recent accreditation by the Liaison Committee on Medical Education, the information was tabulated and is a matter of public record. I present that data (see accompanying table) as a substitute for the information listed on p 44 of the October issue of *Texas Medicine.*

Individual institution figures for 1997 (in millions).

Institution	Annual Revenue	State Appropriations	Patient Care	Uncompensated Care
Texas A&M University (TAMU) Health Science Center (TAMU and Scott & White)	**$876**	**$17 (1.94%)**	**$502**	**$320**

In addition, the information on the total combined research expenditures at our health science center was grossly underreported at the TMA Council on Medical Education meeting, and it also needs to be amended. The combined research expenditures in 1997 were $7.2 million, not $300,000.

I believe these inaccuracies do not reflect any intentional misrepresentation by the author, the state agencies, or Texas A&M University Health Science Center, but merely serve to point out the complexities in attempting to categorize all health science centers in Texas in the same way.

I wish to commend the author for her presentation of the problems facing medical education in Texas, and I would applaud any efforts to enhance our ability to deliver education and health care, and to conduct research for the benefit of the residents of Texas.

Michael L. Friedland, MD
Vice President for Health Affairs
and Dean of Medicine
Texas A&M University
Health Science Center
147 Joe H. Reynolds Medical Building
College Station, TX 77843-1114

Participate, don't alienate

As a commentary on "The World of Medicine in Texas" (September 1998 *Texas Medicine,* pp 34–40), I find it rather ironic that those who have received much from American medicine are the ones that bemoan a few inconveniences. Forty-three years ago when I received my medical degree from a foreign medical school, many states did not accept any

Express your point of view in *Texas Medicine*. To submit a letter, mail, fax, or e-mail it to *Texas Medicine*, TMA, 401 W 15th St, Austin, TX 78701; fax (512) 370-1632; e-mail larry_b@texmed.org. Please type letters you submit for publication, and keep the length to 400 words or less. If necessary, you may include a few references, preferably less than five. Letters are published at the discretion of the managing editor and editorial advisors, and are subject to editing and abridgment. Letters represent the opinions of the authors and do not necessarily reflect the policies of the Texas Medical Association.

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Letters

foreign graduates. Having done part of my formal medical education in an American medical school and part in a foreign one, I could understand the reluctance of the various state medical licensing boards to evaluate and pass on these graduates. Certainly, during the 1950s and 1960s, foreign medical schools presented little information about their facilities and standards.

Regarding the question of cost engendered by the various examinations required for licensure, I find this a minimal inconvenience when one contrasts the out-of-pocket costs in attending an American medical school. This can range from $10,000 to $25,000 or more per annum — no small pittance in contrast to the several thousand dollars in fees for the various testing examinations required for foreign medical graduates.

The United States has always been considered a melting pot, but unfortunately today many citizens have hyphenated themselves. Instead of entering the mainstream of the body politic, they choose to separate themselves voluntarily by ethnic or non-English speech. Many of the problems in other parts of the world stem primarily from this basic problem of several language differences within countries. Religion, language, and cultural differences remain flash points for civil war, violence, and discrimination.

My advice to my colleagues is to become active in your local medical societies, make yourselves known, and thereby lessen the alienation that results from separatism.

As I look back 40 years, I can say to my medical colleagues, "You never had it so good," even though you are earning less for your services. Contrast this to receiving no payment or perhaps half if you were lucky enough. The reward came when you went about the business of treating patients and helping the sick get well.

James E. Tempesta, MD
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is what being a physician

As physicians, effectively communicating with your patients is crucial to ensuring their good health and well-being. Don't miss the dynamic afternoon presentation by Marilyn Moats Kennedy on "Cross-Generational Communications," where you'll learn how to tailor your communication style to each individual, resulting in more positive interactions and improved outcomes with your patients, staff, colleagues, family, and friends.

Marilyn Moats Kennedy is founder and managing partner of Career Strategies, a 21-year-old career consulting firm. She makes more than 100 presentations a year and has written six books on issues such as age diversity, management anorexia, leadership versus management, and organization politics. Kennedy is a columnist for the *Physician Executive* and is often quoted in *The Wall Street Journal* and *Fortune*. She also has appeared on "20/20" and "Good Morning America."

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Commentaries

When you're the gold standard

TMAIT tackles challenges of changing insurance market

By Albert E. Gunn, MD, chair, TMAIT Board of Trustees

Since 1955, the Texas Medical Association Insurance Trust (TMAIT) has provided insurance protection to thousands of Texas physicians, their family members, and their staffs. Through the years, we've added, modified, created, and improved various insurance products to meet physicians' needs and to keep up with rapid changes in health care and insurance.

TMAIT stands head and shoulders above other insurance companies in that TMAIT returns 99% of every premium dollar to its participants in the form of benefits. Its board of trustees and staff carefully monitor and manage operations to minimize costs and promote efficiency. No commercial insurance plan uses just 1% of its premium dollar on overhead.

In today's increasingly automated and impersonal world, TMAIT's personal touch also stands out. Few companies can match our excellence in relationship building, in educating and advising our customers, and in financial counseling.

But some observers are trying to paint TMAIT as an organization in decline. Others downplay it as a relic of a fading past, tailored only for physicians in solo practice. TMAIT is at a crossroads. Changing market forces have shown us that traditional approaches to insurance coverage are no longer as effective as they once were, and we are not standing still.

Because our customer base continues to change, adapting to that change is the most important challenge we face. TMAIT can no longer depend on the male solo practitioner as its mainstay, as more physicians move into group practices and more women enter the profession. We need to better understand these physicians' needs and how we can meet them now and into the 21st century.

We intend to go beyond old comfortable ways, to roll up our sleeves and go after new markets. There can, and will be, a very bright future ahead for this organization and for TMA physicians. Let's look at how and why we believe this.

Meeting the challenge

Demographic changes show that the demand for TMAIT products will remain strong well into the next century; in fact, demand will skyrocket as the first wave of baby boomers reaches retirement age. Although major medical insurance historically has comprised the highest percentage of TMAIT's premiums, the percentage for retirement planning products will grow as our customer base ages.

The TMAIT Board of Trustees demonstrated its commitment to keeping pace with current trends and members' needs when, in 1997, it voted to evaluate proposals for a new underwriter for the insurance program. The board recognized a new era in financial services was beginning and decided to take an active part in shaping the future, rather than simply sticking with the status quo.

Because of the 1997 proposal process, TMAIT won at the negotiating table and now offers physicians higher limits on life insurance and personal accident insurance. We also added new products such as long-term care, worldwide travel coverage, and level premium life insurance. Most importantly, the process validated our belief that the financial arrangement between TMAIT and its underwriter is the most equitable and efficient arrangement available for TMA physicians.

By choosing to become a player in the retirement security market, TMAIT is positioned and ready to bring its strengths and high-quality service to TMA physicians in these critical areas. We are expanding our product line from one that has been focused almost solely on life and health insurance to one that covers the broader spectrum of asset accumulation and retention. For example, the long-term care insurance product we offer is designed to satisfy consumers' needs to protect them against financial uncertainty.

In reality, everyone's financial future is riddled with uncertainty. There are no clear answers for how long we will live, whether we will become disabled or will need nursing home care, or if we will need to leave money for dependents.

With its variety of insurance products, TMAIT is well suited to help physicians manage these financial uncertainties. Long-term care insurance helps physicians take care of themselves or their parents in their final years. Disability insurance provides income after a disabling illness or injury.

TMAIT already is developing distribution systems to respond to customers' changing buying habits. We are armed with innovative products, just the right technology, and over-the-top service and expertise. On top of this, we will always be a strong and dependable organization for those who already rely on us.

TMAIT's highest priority is to maintain a financially solvent and stable insurance program in which its members have the greatest confidence that benefits will be paid as promised. And we have accomplished this by fully insuring the program with strong and reputable insurers, by managing the program responsibly, and by maintaining adequate, but not excessive, premium rates. And, our premium stabilization fund acts as a buffer to accommodate unanticipated fluctuations in claims.

We can only imagine the innumerable changes TMAIT will face in the future. But already we are improving our member services in response to change. Certainly TMAIT is a solid organization that will remain solid, and we will continue to recognize coming challenges as opportunities. TMAIT will thrive in the future and build upon almost 50 years of serving Texas physicians and their families. ★

Albert E. Gunn, MD, is deputy chair of the Department of Internal Medicine Specialties and chief of the Geriatrics Section of The University of Texas M.D. Anderson Cancer Center in Houston.

Boom or bust

Insurance industry ups and downs are nothing new

By Philip S. Dial

Throughout most of the 20th century, insurance has been one of the most cyclical industries in American commerce. While some lines of coverage, such as long-term disability, have been relatively steady, others, like health insurance, have been highly cyclical. In a typical cycle, intense competition stimulates price-cutting and market expansion, followed by rapidly rising premium rates and tightening markets.

Slow on the draw

In the health insurance business, particularly in the last 25 years, these cycles often have been driven by a "too little too late" or "too much too late" approach to premium increases. Insurance underwriters, who set rates for insurance companies, have been slow to recognize, and even slower to address, changing trends in health care claims. And when they finally did respond, they typically overreacted. Rates periodically became excessive and the surplus income created an unfounded sense of security. This false sense of security led to deferring necessary rate increases, which led to premium deficiencies, which triggered financial losses, which necessitated rate increases. Eventually, a new cycle would begin.

Ignoring its own historical lessons, the entire insurance industry began a cycle of intense competition in the last half of the 1980s. First, the property/casualty business aggressively began marketing liberal benefits and relatively inexpensive prices. Intense competition soon spread throughout the industry until it eventually reached one of the last lines to be affected — health insurance. This intensely competitive phase, characterized by underpriced products flooding the market, has lasted much longer than earlier cycles. Recently though, the health insurance market began a shift back to substantial rate increases.

Although the health insurance industry has experienced ups and downs since the 1960s, a strong backlash from purchasers reacting to high costs led to the development and rapid growth of the managed care industry. Intense competition for the health care dollar followed. Throughout the 1980s, health insurers moved away from the traditional fee-for-service indemnity model toward managed care arrangements such as health maintenance organizations (HMOs), preferred provider organizations (PPOs), and point-of-service (POS) plans. Managed care's intense focus on costs and the bottom line has affected all aspects of medical practice.

The move to managed care was slow initially, but by the early 1990s, intense competition had struck the health care industry. In Texas, commercial HMOs and a growing number of provider-sponsored managed care organizations have waged a heated battle for market share since 1993. The ever-intensifying focus on price resulted in the inevitable decline in both the popularity and availability of fee-for-service indemnity health insurance, the price of which continued to escalate. As the price disparity between managed care products and indemnity insurance increased, more and more consumers, and eventually even physicians themselves, "rose above principle to practicality" as costs dictated their move to managed care.

Texas has seen a huge boom in managed care, even in many rural areas. Managed care plans have ranged from relatively sophisticated, well capitalized and professionally managed organizations to underfunded, poorly conceived late entrants to the business. As often happens in the insurance industry, the resulting aggressive competition fatally undermined indemnity insurance while simultaneously creating an environment that led to massive

losses for managed care companies.

Just as the industry was competing itself into a financial corner, consumers and providers gained momentum in their fight for stronger regulation of managed care companies. During 1997, advocacy groups gained a major foothold in most state legislatures and in Congress, winning greater regulatory controls and increasing managed care's exposure to liability for its utilization management decisions. This emboldened physicians and other health care providers to become more aggressive in pricing their services. These combined forces heightened financial pressures on the already battered managed care industry.

In Texas, this activity led to a recent and significant industry consolidation. In 1997, Humana purchased PCA Health Care, Inc, and United HealthCare purchased Travelers. In 1998, Aetna US Healthcare purchased NYLCare. These 3 major mergers have reduced coverage options in most of the larger markets in Texas. In addition, merger discussions continue for some of the state's smaller HMOs that also have experienced financial difficulty.

Looking at 1999 and beyond, significant rate increases are appearing throughout the health insurance industry as carriers respond to deteriorating financial returns, an increasingly regulated environment, and providers who are more aggressive in their negotiations. The health insurance industry seems to be entering a new cycle of more rapidly increasing prices that could last for several years until financial results stabilize. This inevitably will lead to increased pressure on businesses, consumers, and government to once again address rising health care costs. The potential exists for the pendulum to swing away from consumers' and providers' interests and back to a bottom-line focus on costs.

From safety to peril

Meanwhile, revolutionary developments in health care financing have had a dramatic effect on another line of coverage near and dear to physicians' hearts — long-term disability (LTD) insurance.

Insurance underwriters, who set rates for insurance companies, have been slow to recognize, and even slower to address, changing trends in health care claims.

During the 1970s and 1980s, the disability insurance industry targeted the most attractive and profitable segment of the LTD market — professionals — with a strong emphasis on physicians. The industry recognized that highly paid, security-conscious professionals were an excellent source of business. Highly educated and deeply dedicated to their professions, for many years physicians seemed to provide the perfect risk. Because of their work ethic and love of the profession, few physicians became disabled, and most who did, returned to work as soon as possible. As a result, competition for this market segment intensified, resulting in liberalized benefits, loosened underwriting standards, shrinking prices, and long-term, often ill-conceived guarantees.

Success in such an environment depends on the forces that had created it to stay the same — a high level of job satisfaction and financial security among those insured. Unfortunately, the growth of managed care has had a dramatic impact on many physicians. They have experienced loss of professional autonomy, reduced income, increased administrative and bureaucratic inconvenience, and ultimately, loss of job satisfaction. As a result, the disability rate among physicians began to increase rapidly in the early 1990s. By the middle of this decade, the number of claims had doubled. Worse yet, once on disability, physicians tended to stay on it. This phenomena has had broadly adverse implications for programs as diverse as the group insurance plan provided by the Texas Medical Association Insurance Trust (TMAIT) and individual, noncancelable coverage issued by the largest disability insurers in the country.

As poor underwriting results became apparent, insurers moved to address the problem. Generally, they made benefits less generous, reduced guarantees, and increased premium rates, and some insurers left the market. Such moves were painful for everyone: the underwriters, the agents who sold the coverage, and the insured professionals who experienced reduced benefits and increased costs. TMAIT experienced large financial losses.

But in spite of such measures, the problems with LTD are probably not over. Because professional unrest in medicine probably will continue for some time, it is likely that more physicians will use their disability plans.

More competition ahead

As both a financial institution and a source of personal security, insurance is as complicated as it is important. Because it has become essential to Americans' sense of well-being, the industry will continue to receive close scrutiny as it evolves into the next century. Cyclical competitive conditions are likely to continue simply because of the tremendous amount of money involved. And with banks and other financial intermediaries entering the insurance business, competition undoubtedly will increase and innovation will become more important. Some new products will work, many others will not. But hopefully, the industry will learn from these mistakes and develop new and improved products to better meet consumers' changing needs. ★

Philip S. Dial, FSA, is with Rudd and Wisdom, Inc, in Austin, and is a consultant actuary for the Texas Medical Association Insurance Trust.

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People

Newsmakers

The new officers for the Medical Alumni Association at The University of Texas Health Science Center at San Antonio include endocrinologist **Richard Becker, MD,** president; pediatrician **Daniel Sedillo, MD,** treasurer; and otolaryngologist **Richard Newman, MD,** immediate vice president.

Houston general surgeon **Richard E. Caplan, MD,** and Temple general surgeon **John Hendricks, MD,** were named cancer liaison physicians to the American College of Surgeons Commission on Cancer.

Cardiovascular surgeon **Michael E. DeBakey, MD,** was honored with a scientific colloquium and a gala dinner on his 50th anniversary with Baylor College of Medicine in Houston.

El Paso allergist **Edward Egbert, MD,** was named the 1998 Distinguished Alumnus by The University of Texas-El Paso.

Houston urologist **Paul B. Handel, MD,** was appointed by former Texas Commissioner of Insurance Elton Bomer to the Task Force on Physician Incentive Payments, which will study physician reimbursement by managed care plans.

Dallas internist **Benjamin Levine, MD,** was awarded the 1998 Research Award by the Wilderness Medical Society for his work on the physiological effects of altitude and exercise.

Dallas urologist **John McConnell, MD,** was appointed to the National Diabetes and Digestive and Kidney Diseases Advisory Council of the National Institutes of Health by US Secretary of Health and Human Services Donna Shalala.

Anesthesiologist **Tod B. Sloan, MD, PhD,** received a 1997 Presidential Award for Excellence in Teaching at The University of Texas Health Science Center at San Antonio.

Fort Worth general surgeon **John H. Smith, MD,** received the 1998 Gold-Headed Cane Award from the Tarrant County Medical Society.

Hematologist **Charles Sprague, MD,** former president of The University of Texas Southwestern Medical Center at Dallas, was honored with the establishment of the Charles Cameron Sprague, MD, Chair in Medical Science by UT Southwestern.

Pediatrician **Joel B. Steinberg, MD,** received the Robert L. Moore Award for Medicine for his many years of devoted and caring service to Children's Medical Center of Dallas.

Paul B. Handel, MD

Benjamin Levine, MD

Raleigh R. White IV, MD

Clyde Yancy, Jr, MD

Temple plastic surgeon **Raleigh R. White IV, MD,** was named president-elect of the Texas Surgical Society.

Dallas cardiovascular disease specialist **Clyde Yancy, Jr, MD,** was installed as president of the American Heart Association, Texas Affiliate.

Deaths

Hugh Fuller Arnold, MD, 79; Houston; The University of Texas Medical Branch at Galveston, 1941; died October 9, 1998.

Please let *Texas Medicine* know about your honors and achievements. Criteria for inclusion in the Newsmakers section are TMA membership; election or appointment to an office of, or honors from, a national or state organization; or, space permitting, recognition at the local level. Items for the Newsmakers section are published at the discretion of the managing editor. Submit items for consideration, with photos if possible, to Johanna Franke, People, *Texas Medicine*, 401 W 15th St, Austin, TX 78701; fax (512) 370-1632; e-mail johanna_f@texmed.org.

Transitions: Legal Considerations in Selling or Closing a Medical Practice

by Hugh M. Barton, JD

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People

Edwin Ray Ballinger, MD, 78; Manchaca; George Washington University School of Medicine and Health Sciences, 1947; died June 15, 1998.

Louis Burkhalter Barkley, Jr, MD, 61; Midland; The University of Texas Southwestern Medical School at Dallas, 1962; died October 21, 1998.

William Henry Barth, MD, 65; Corpus Christi; Baylor College of Medicine, 1957; died October 19, 1998.

Douglas Baxter Black, MD, 78; Lamesa; University of Tennessee, Memphis, College of Medicine, 1943; died October 24, 1998.

John Armistead Boston, Jr, MD, 74; Jacksonville; Temple University School of Medicine, 1948; died September 14, 1998.

James Donald Carter, MD, 69; Houston; University of Arkansas for Medical Sciences College of Medicine, 1954; died October 14, 1998.

Frederick Heuston Davis, MD, 77; Dallas; University of Toronto Faculty of Medicine, 1943; died April 1, 1998.

Ernest Evan Denney, MD, 74; Austin; Emory University School of Medicine, 1951; died August 12, 1998.

George Franklin Dillon, MD, 85; Big Spring; University of Tennessee, Memphis, College of Medicine, 1941; died October 24, 1998.

Jack Walter Dworin, MD, 83; Naples, Fla; University of Illinois College of Medicine, 1940; died February 3, 1998.

David E. Fader, MD, 88; Dallas; Louisiana State University School of Medicine-New Orleans, 1936; died November 1, 1998.

Allen Maurice Fain, MD, 76; Duncanville; The University of Texas Southwestern Medical School at Dallas, 1951; died October 23, 1998.

People

Howard Zamor Fretz, MD, 81; Wharton; The University of Pennsylvania School of Medicine, 1942; died July 31, 1998.

Bekir Guzeldere, MD, 66; Sugar Land; The University of Istanbul Medical Faculty-Turkey, 1957; died October 6, 1998.

Bobby Jones, MD, 76; Houston; Baylor College of Medicine, 1947; died November 2, 1998.

William Arthur Jones, MD, 75; Mauk, Ga; University of Nuevo Leon-Monterrey, Mexico, 1954; died October 31, 1998.

James Dudley Mayberry, MD, 60; San Antonio; University of London, 1963; died November 16, 1997.

Homer Ronald Newman, MD, 59; Port Neches; The University of Texas Medical Branch at Galveston, 1965; died October 30, 1998.

Paul Marion Pumphrey, MD, 74; Fort Worth; The University of Texas Southwestern Medical School at Dallas, 1960; died November 2, 1998.

Raymond Harrison Rigdon, MD, 82; Madison, Ga; Emory University School of Medicine, 1931; died July 28, 1998.

Jack Joseph Rosenberg, MD, 61; San Antonio; The University of Texas Medical Branch at Galveston, 1962; died October 6, 1998.

John Howard Sheets, MD, 70; Odessa; Case Western Reserve University School of Medicine, 1953; died October 24, 1998.

Rush Alexander Snyder, MD, 89; Canadian; University of Tennessee, Memphis, College of Medicine, 1945; died October 6, 1998.

Harvey King Truett, MD, 89; McKinney; Baylor College of Medicine-Dallas, 1937; died February 24, 1998.

Robert Watkins Webb, MD, 92; Dallas; Tulane University School of Medicine, 1933; died October 29, 1998.

A Capitol Salute

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Texas Medicine Rounds

By Johanna Franke

Silver session

Patients, minority students win big at interim's 25th anniversary

Physicians took actions to protect their patients, showed their support for a new minority scholarship program, and prepared for the 76th session of the Texas Legislature at the Texas Medical Association House of Delegates Interim Session November 20–21 in Austin.

Noting that Texas' lawsuit against the tobacco industry was intended to compensate the state for the cost of treating tobacco-related diseases, the House adopted a 3-part recommendation on how the $17 billion from the lawsuit should be spent. Delegates said that as a "matter of unwavering principle," TMA should work to convince the legislature to dedicate the money to improving the health of all Texans, including direct medical care, prevention, and research, and that a majority of the funds should be allocated to patient care for tobacco-related illnesses. They also expressed TMA's strong support for efforts to fully fund the Memorandum of Understanding between the attorney general and legislative leaders that dedicates the first round of the tobacco dollars to improving Texans' health (see "Do the Right Thing," pp 34-38).

After considering more than 70 resolutions and reports dealing with socioeconomic, medical education, scientific, public health, financial, and organizational issues, the House also voted to:

- Support AMA policy against "quantitative formulas" or the assignment of "numeric values" by Health Care Financing Administration evaluation and management guidelines, and oppose any proposed guideline that could criminalize the patient-physician encounter.
- Oppose the mandatory use of hospitalists and intensivists by insurers and recommend that hospital bylaws not prohibit a patient from having his or her primary physician provide continuity of care.
- Oppose unilateral claims downcoding and bundling by insurance carriers.
- Support passage of laws against using patient drug information for marketing purposes.
- Support legislation to reduce underage drinking.

TMA President John P. Howe III, MD, of San Antonio, left, donates the first check, displayed by TMA House of Delegates Speaker Tom B. Hancher, MD, of Columbus, to the TMA Minority Scholarship Program, which Dr Howe unveiled at interim session. "We who care deeply about Texas medicine in the new millennium can make a difference by joining in this scholarship program of much importance to the future of our profession and our association," Dr Howe said.

- Approve the White Paper on Teen Pregnancy Prevention prepared by the Special Task Force on Teenage Pregnancy Prevention.
- Urge TMA to work with police to ensure that blood alcohol or drug screens are obtained on drivers involved in traffic accidents causing fatal or serious injuries.
- Urge medical schools to assess the adequacy of their curricula to prepare medical students and residents to respond to the special needs of patients requiring palliative care, and encourage the development of continuing medical education courses on clinical and ethical issues related to end-of-life care.
- Support legislation to limit county charges for recovering tissue to the recovery of operational costs.
- Reaffirm TMA policy that state medical schools should continue to be funded at a level allowing them to continue providing excellence in medical education, research, and patient care.
- Appoint an ad hoc committee of TMA and TMA Alliance members to develop joint initiatives to increase membership of both.
- Combine the fall leadership conference and the interim session of the House of Delegates into one meeting held on an intermediate weekend date.
- Refer to the Board of Trustees the issue of TMA organizing county medical society employees into a group to provide employment benefits.
- Refer to the Council on Legislation a recommendation that TMA seek legislative amendments to clearly prohibit hospitals from restricting physicians' full participation in hospital leadership positions.
- Disapprove a recommendation that TMA support regulation and licensing of nurse practitioners by the Texas State Board of Medical Examiners.
- Disapprove a recommendation that motorcycle riders be required to provide proof of adequate personal injury insurance coverage before registering a motorcycle.

The House also voted to approve the TMA Board of Trustees Report that the *Hopwood* decision has had a negative impact on minority medical school enrollment and that TMA supports efforts to reverse its effect. One effort that was introduced during Saturday's session by TMA President John P. Howe III, MD, is the TMA Minority Scholarship Program.

Dr Nixon to receive Distinguished Service Award

More than 4 decades of commitment to family practice and to the family of medicine have prompted the Texas Medical Association House of Delegates to approve enthusiastically the nomination of Sam A. Nixon, MD, of Nixon, for TMA's Distinguished Service Award. Dr Nixon will receive the award at TexMed '99 in Dallas.

Dr Nixon graduated from The University of Texas Medical Branch at Galveston and served his country in the US Army Medical Corps in Korea and Japan before embarking on his medical career in Texas. After 23 years as a devoted family physician in Nixon and Floresville, Dr Nixon moved to Houston to teach in the Department of Family Practice and Community Medicine at The University of Texas-Houston Medical School in 1977. He also served as preceptor and professor in the surgery department, director of the Division of Continuing Education, special assistant to the president for governmental and professional relations, and faculty associate at the Center for Health Promotion, Research and Development.

A former chair of the TMA Council on Public Health, Dr Nixon also has served organized medicine through various duties for the Harris County Medical Society and the American Medical Association. After being appointed to the AMA Council on Environmental, Occupational, and Public Health and the Council on Continuing Physician Education, Dr Nixon was elected to the AMA Council on Medical Education and served as its chair in 1991 and 1992. He also has served as an AMA representative to the Accreditation Council for Continuing Medical Education and has been an AMA delegate since 1977.

Dr Nixon, a former president of both the Texas Academy of Family Physicians and the American Academy of Family Physicians (AAFP), serves on the Board of Curators of the Archives of the AAFP Foundation and has chaired the State Rural Medical Education Board since 1975. He also is a member of the Family Medicine Foundation of Texas Board of Trustees, having served on the board of the Family Health Foundation of America.

Among his many honors was Dr Nixon's appointment as a member of the Board of Regents of the Uniformed Services University of the Health Sciences by President Ronald Reagan in 1985. A former consultant to the Centers for Disease Control and Prevention and the US Public Health Service, Dr Nixon is a member of the Society of Medical Consultants to the Armed Forces. He has served his community as chief of staff at Memorial Hospital in Floresville, general manager of Floresville Nursing Home, vice president of the Nixon School Board, director of the Wilson County Health Department, and director of the South Texas Chamber of Commerce.

In other House of Delegates action in November, Houston oncologist Joseph T. Painter, MD, was elected to emeritus membership, and El Paso family physician Walter C. Autrey, MD, and Crosbyton family physician Dale R. Rhoades, MD, were elected to honorary membership.

"Your colleagues have developed a program to send the message across the state and the nation that Texas physicians care about diversity in medicine and have taken steps to make this happen," Dr Howe said. The program, supported solely by member donations, will provide financial assistance to qualified, underrepresented minority students who attend Texas medical schools. The scholarship recipients will be encouraged to remain in the state to practice where they are needed most.

During Friday's session, members of TMA's Council on Legislation gave delegates a preview of the 1999 Texas legislative session, which will focus heavily on redistricting issues (see "Legislating Health," pp 28-33). TMA will be playing more of a defensive role to retain the successes earned during the 75th legislative session, according to council members. "This session's issues will be more technical, more socioeconomic, and are likely to be very, very contentious," said Robert Sloane, Jr, MD, chair of the Council on Legislation. "We promise to keep you and all of our colleagues across the state up to date."

The House of Delegates elected Charles W. Bailey, Jr, MD, of Houston, as a delegate to AMA to replace Fred F. Castrow, MD, of Houston, who resigned; and elected Joel S. Dunnington, MD, of Houston, as an alternate delegate to AMA. ★

David Duffner, MD, of Tyler; Council on Legislation Chair Robert Sloane, Jr, MD, of Fort Worth; and Michael S. Parish, MD, of Austin, present a primer on the 76th session of the Texas Legislature to the delegates at interim session.

Max Butler, MD, of Houston, back left; Al Hendler, MD, of Dallas, back center; and C.L. Montgomery, MD, of Lubbock, back right, receive applause from TMA President John P. Howe III, MD, front left; TMA Secretary-Treasurer George E. Thannisch, MD, front right; and the rest of the House of Delegates in recognition of their many years of service to TMA's Delegation to the American Medical Association. Drs Butler, Hendler, and Montgomery retired from the delegation along with Harold High, MD, of Cuero, who could not be present for the commendation.

TMA Medical Student Section (MSS) Chair Stanley Wang, of Dallas, left, and TMA-MSS Reporter Brad Butler, of College Station, prepare for action on the House floor.

Delegate Richard D. Jablonski, MD, of Houston, studies the more than 70 resolutions and reports considered at interim session. A summary of House actions can be found in the "Members Only" section of the TMA Web site at www.texmed.org.

American Medical Association Board of Trustees Chair Randolph D. Smoak, Jr, MD, and AMA Executive Vice President E. Ratcliffe Anderson, Jr, MD, paid the House a surprise visit on Saturday. Dr Smoak told the delegates, "The AMA intends to be there for you, with you, to fight for our profession, to fight for what matters, and to fight for our patients."

WEB SITES OF INTEREST TO TEXAS PHYSICIANS BY JOHANNA FRANKE

MedBytes

Prepare for the 76th Texas Legislature and the 106th US Congress with Web sites featured in this month's "MedBytes."

Texas Legislature Online

For the ultimate source on state legislative news, type in www.capitol.state.tx.us. Texas Legislature Online offers state House and Senate calendars, committee membership lists and schedules, Texas statutes, general legislative information, legislative district information, a Capitol Complex schedule, and a copy of the Texas Constitution. Visitors to the site can search for bills and amendments and obtain information on their state senators and representatives.

Congressional news

THOMAS: Legislative Information on the Internet, located at thomas.loc.gov, offers US House and Senate directories as well as links to the executive and judicial branches. Sponsored by the Library of Congress, THOMAS allows visitors to search for bills by topic, number, title, or type, and provides a primer on how a bill becomes a law.

Branching out

Another good source for information on the US legislative branch can be found at lcweb.loc.gov/global/legislative/congress.html. The site contains congressional member, committee, and calendar information; House and Senate rules; a listing of floor proceedings; and a congressional record index.

TMA's legislative hotline

TMA members who want the latest news on legislative actions affecting health care delivered right to their computers every day can subscribe to the electronic TMA News Hotline. TMA will e-mail legislative updates to subscribers every Monday through Friday from the opening day of the 76th Texas Legislature on January 12 through the final gavel on May 31. Plus, every Friday subscribers will receive TMA's News Hotline Replay, which summarizes the most important news of the week. The hotline and replay also will carry important call-to-action messages to let subscribers know when to contact their representatives and senators to seek their support on critical issues. To subscribe to TMA News Hotline, log in to the "Members Only" section of the TMA Web site at www.texmed.org. Select "Physicians Lounge," then "E-mail Lists." Or send your e-mail address to ken_o@texmed.org. Daily reports also will be posted on the TMA Web site under "Legislative News" in the "Physician Advocacy" section of the "Members Only" area.

In living color

Be sure to drop by the Texas Medical Association Web site at www.texmed.org before January 31 to sign up for the first TMA Cyber Sweepstakes of the new year. TMA members who provide or confirm their e-mail addresses through the "Members Only" section before the end of the month are automatically entered to win a color Hewlett Packard ScanJet 5100Cxi scanner. Your e-mail address will be used to contact you with breaking health care news.

MedBytes is a quick look at new, or newly discovered, Web sites of interest to Texas physicians. The column also highlights features of the TMA Web site at www.texmed.org. If you know of some cool medical sites or have questions about how to use the TMA Web site, e-mail johanna_f@texmed.org. Publication of information about Web sites in this column is not to be considered an endorsement or approval by the Texas Medical Association of the sites or sponsors, or of any products or services involved.

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TMA switchboard (800) 880-1300

Impaired physicians (800) 880-1640
Call this 24-hour hotline to report information concerning physicians who may be abusing alcohol or other drugs, or who may be chemically addicted, psychiatrically impaired, or have other problems. All calls are confidential.

Insurance (800) 880-8181
The Texas Medical Association Insurance Trust offers life, health, disability, office overhead, personal accident, and other insurance plans and products to TMA members, their families, and office staffs.

Loans (800) 880-2828
TMA offers qualified medical students and residents low-interest loans. Call for general requirements and application procedures.

TEXPAC (800) 880-1300, ext 1362
The TMA Political Action Committee speaks on behalf of physicians through grassroots involvement, personal relationships with elected officials, and political campaign participation and contributions.

TPSO (800) 523-8776
The Texas Physician Services Organization delivers physicians and physician organizations an array of products and services to help them succeed in the changing medical marketplace.

Use the following prefixes plus @texmed.org to e-mail for TMA resources.

General Information	info
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Sneak Preview	sneakpreview
Specialty Societies	ssms
TMA Alliance	tmaa
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Texas Physician Services Organization	tpso

Medicaid providers encouraged to reenroll

National Heritage Insurance Company (NHIC), under the direction of state Medicaid agencies, has begun to reenroll all Medicaid providers. The initiative is driven by Senate Bill 30, which was enacted by the Texas Legislature in 1997 and requires all Medicaid providers to reenroll in the program by September 1, 1999. The statute also obliges providers to sign a new agreement stipulating that they will comply with the state's Medicaid program integrity efforts.

Information collected from reenrollment will be used to update the NHIC provider database, which currently contains many inaccuracies, and to streamline Medicaid provider numbers into 1 unique identifier beginning next November. In other words, by 2000, participating Medicaid providers will no longer have to use different provider numbers for distinct programs, such as Texas Health Steps and the school-based clinic program.

Reenrollment originally was set to begin October 16, but at TMA's request, the Texas Health and Human Services Commission and the Texas Department of Health postponed the start date a month to address concerns about the reenrollment application and provider agreement. TMA's advocacy resulted in substantial revisions to the new forms.

Providers are strongly encouraged by NHIC to return completed packets quickly. After June 1, 1999, NHIC cannot guarantee that packets will be entered into the new database before the September 1 cutoff. Providers who fail to return a completed reenrollment form by September will be disenrolled from the program. Reminder notices will be mailed.

Physicians who currently have multiple provider numbers received duplicate packets, though only 1 must be returned. An exception exists for some group-based physicians who practice at multiple locations.

For questions about the reenrollment process or if you did not receive a form, please contact NHIC customer relations at (800) 925-9126. ★

Managed care hits rural communities

After escaping its grips for many years, rural communities in Texas are now feeling the squeeze of managed care. Local access, clinical autonomy, and vital health care dollars are being threatened. To help physicians, patients, and hospitals in the 196 Texas counties with fewer than 50,000 residents preserve local control over their own health services, the Texas Legislature created the Rural Community Health System (RCHS) in 1997. The system was formed with the support of the Texas Medical Association, Texas Academy of Family Physicians, Association of Texas Hospitals and Health Care Organizations, and Texas Organization of Rural and Community Hospitals.

RCHS, a nonprofit organization, will provide administrative, financial, and technical support to locally organized systems. The goal is to keep health care resources, patients, and dollars in the community, says Helen Kent Davis, director of governmental affairs for TMA. "We want to combine the emerging trend of managed care with local access, local control, and local financing," she said. Harold High, MD, of Cuero, who serves as president of the 18-member RCHS Board of Directors, believes that without such intervention, most of the state's rural hospitals will close in the next few years and many practicing physicians will be forced to leave.

While the legislation, SB1246 introduced by Sen Frank Madla, Jr, (D-San Antonio), recognized the need for RCHS, there was no funding mechanism. Dr High says the group will be requesting some $20 million from the legislature this year to capitalize the venture. Without that money, he said, RCHS "is dead in the water; it's just that simple."

To learn more about RCHS, contact Helen Kent Davis at (800) 880-1300, ext 1401, or (512) 370-1401; or e-mail helen_d@texmed.org. ★

SUMMARIES OF RECENT HEALTH CARE HEADLINES

In Case You Missed It

By Melissa McEver

A low-birth-weight newborn may be at risk of becoming an obese child or adult, a recent study suggests. Researchers at the **NATIONAL INSTITUTE OF CHILD HEALTH AND HUMAN DEVELOPMENT** found underweight infants after birth quickly gain more fat relative to their size than normal weight infants, often leading to childhood obesity. The researchers believe this rapid gain of fat is because undernourished fetuses seem to be programmed to compensate for the lack of nourishment after birth. Parents also tend to overfeed their underweight babies, the researchers said.
(*Pediatrics*, 11/98)

A mind is a terrible thing to waste, and college drinking habits may cause more harm to a young mind than realized. Researchers at **DUKE UNIVERSITY MEDICAL CENTER** found that drinking alcohol may have a greater effect on a college-aged person's brain than on the brain of someone older. The scientists asked 21 to 24 year olds to remember words from a list after ingesting 2 alcoholic drinks and compared their accuracy with that of 25 to 29 year olds who consumed an equal amount. The older adults did better on the tests.
(*Alcoholism: Clinical and Experimental Research*, 11/98)

Staying away from red meat may not mean staying away from colon cancer risk, a new study has found. Scientists at the **CENTER FOR HEALTH RESEARCH AT LOMA LINDA UNIVERSITY IN CALIFORNIA** used information from a study of Seventh-day Adventists, who are mostly vegetarian but sometimes eat meat. They found that the participants who sometimes ate white meat had a 55% higher risk of colon cancer than those who were strictly vegetarian. The researchers don't know why white meat seems to increase cancer risk, except that diets high in fat and meat intake long have been associated with colon cancer.
(*American Journal of Epidemiology*, 10/15/98)

A new kind of pacemaker can offer hope for stroke prevention, Dutch physicians recently reported. The device, called the Atrioverter, corrects the heart defect known as atrial fibrillation, scientists at **ACADEMIC HOSPITAL IN MAASTRICHT** found. Atrial fibrillation can cause rapid heartbeat, chest pain, and fainting, and also can cause the blood to pool and clot, leading to a stroke if the clot travels to the brain. This device may help the 50% of patients with atrial fibrillation who aren't helped by drugs, an editorial by Mark Josephson, MD, concluded.
(*Circulation*, 10/20/98)

BEFORE YOU SIGN

Contract TIPS

Things you need to know

When it comes to managed care organization (MCO) contract concerns, payment issues generally rank at the top of the list. Avoid potential payment hassles by asking the following questions before you sign.

- **How long do I have to submit a claim? Do you require a special, nonstandard claim form? What is your claim payment time? Who will help me if I have a question or problem regarding claim payment?**
- **On what do you base your fees? How often are your fees updated? Will you provide me with your fees for my 20 most frequently billed CPT codes for a fee analysis?**
- **Does the MCO have a list of services by CPT code that are covered by the MCO? Can I bill the patient for services provided that are not covered by the MCO?**
- **Which procedural CPT codes are included in my capitation rate?**

Source: TMA's Texas Physician Services Organization (TPSO). For more information about TPSO services or to request a copy of the TPSO catalog, call (800) 523-TPSO or (512) 370-1418; or e-mail tpso@texmed.org.

Winter conference speaker bridges generation gap

Are you a Boomer or a Buster, or maybe a Cusper? Do you buy American or is foreign more prestigious? Do you fit in well in new surroundings or do you avoid social engagements at all costs? Are you technically savvy or technically challenged? Will your children rebel or will they live at home forever? You can learn the answers to these and many other generational quandaries from Marilyn Moats Kennedy, who will present a special afternoon program at TMA's 1999 Winter Leadership Conference February 27 at the Renaissance Austin Hotel.

Regardless of your age, you need to understand some of the differences in communication styles among various generations that must be overcome if people are to work well together. As physicians, you can learn to talk to your staff and patients with better results, fewer misunderstandings, and smoother relationships. As physician leaders, you can learn to tailor your management style to your audience, resulting in more positive interactions, increased participation, and improved outcomes.

Ms Kennedy is founder and managing partner of Career Strategies, a 21-year-old career consulting firm. During her 30 years of experience, she has been a university faculty member, business owner, consultant, and nationally known speaker. She makes more than 100 presentations a year and has written 6 books on issues that affect the evolving workplace, such as age diversity, management anorexia, leadership versus management, and organization politics. Ms Kennedy is currently a columnist for the *Physician Executive, Across the Board,* and *Manager's Intelligence Report.* She often is quoted in *The Wall Street Journal* and *Fortune.* Ms Kennedy also has appeared on "20/20" and "Good Morning America."

To register for this program, contact Amy Edwards, Special Services, at (800) 880-1300, ext 1346, or (512) 370-1346; or e-mail amy_e@texmed.org. ★

New York Nights

Spend a New York night with TMA Foundation

Start spreading the news! TMA Foundation will host its sixth annual benefit, "New York Nights," May 7, 1999, at the Wyndham Anatole Hotel in Dallas.

Guests will enjoy a lively evening in Manhattan's most chic nightclub, including a martini bar, dinner, and silent auction. The benefit, held in conjunction with TexMed '99, also will feature Sinatra, Big Band, and Tin Pan Alley sounds for dancing. Attire for the evening is New York chic — casual to festive.

For more information or to obtain tickets for the benefit, call Lisa Stark Walsh, TMA Foundation, at (800) 880-1300, ext 1666, or (512) 370-1666; or e-mail lisa_w@texmed.org. ★

UNT professor appointed to FBI advisory board

He may be no Mulder or Scully, but Arthur Eisenberg, PhD, has been appointed chair of the Federal Bureau of Investigation's (FBI's) DNA Advisory Board by FBI Director Louis Freeh.

Dr Eisenberg, an associate professor of pathology at the University of North Texas Health Science Center at Fort Worth, recommends standards to Director Freeh for DNA quality assurance and forensic laboratory proficiency testing. Since 1995, Dr Eisenberg has served as the molecular geneticist for the board, which is composed of 16 other scientists and crime laboratory specialists. ★

PAIRS offers training to help Texans with heart disease

Texas physicians now can refer their patients to Practical Application of Intimate Relationship Skills (PAIRS), an internationally acclaimed program that teaches interpersonal techniques to patients with heart disease to improve their overall health.

"Recent studies have found that patients with heart disease are much more likely to recover if they improve interpersonal relationships," said Kelly Simpson, the Texas PAIRS coordinator. "PAIRS is an educational program that teaches relationship skills to promote and sustain better health. It is not therapy — it is education."

Health care professionals can become licensed to teach the PAIRS program, or physicians can refer their patients to the program. For more information, consult the PAIRS-Texas Web site at www.pairstexas.com, or call (214) 369-5717. ★

Baylor facility designated center of excellence

Baylor College of Medicine's Huffington Center on Aging has been designated a Center of Excellence in Geriatrics by the John A. Hartford Foundation.

The Hartford Foundation will contribute $200,000 annually for 3 years to the center, which is 1 of 8 national sites in the Geriatric Interdisciplinary Team Training (GITT) project. The funding will help GITT use classroom time and clinical rotations to foster a team approach to geriatric care among a variety of health care professionals.

The University of Texas-Houston Health Science Center and the University of Houston are academic partners with Baylor in the GITT project, which will train more than 450 health care workers in the 3-year program. Results of the program will be shared with other GITT centers across the country. ★

TexMed '99 features new educational tracks

For the first time, general educational tracks will be offered at Texas Medical Association's TexMed '99, May 6–9 in Dallas at the Wyndham Anatole Hotel. Specialty sections and scientific and socioeconomic symposia will be presented as well. These new tracks will be of interest to a broad range of physicians and will include:

- Ethics – End of Life Care
- Clinical Practice of Medicine
- Computers in Medicine/Technological Advances in Medicine
- Alternative/Complimentary Medicine
- Business Practice of Medicine
- Socioeconomics

The educational tracks are intended to provide timely and useful information on topics that would not usually be addressed at specialty meetings. They will vary in length from a half day to 2 days and are planned for Friday and Saturday, May 7 and 8.

For more information on TexMed '99, contact Paula Rigling at (800) 880-1300, ext 1450, or (512) 370-1450; e-mail paula_r@texmed.org; or visit TMA's Web site at www.texmed.org. ★

TexMed'99

Texas Medical Association Educational Showcase & Expo

May 6-9, 1999 Dallas, Texas

TIPS ON HOW TO PUT YOUR PATIENTS FIRST

BEST Practices

Texas Medicine **recently received the following anonymous tips from our readers on how to improve the patient-physician relationship.**

- **Apologize to patients when you're behind schedule. Let them know you realize their time is valuable, too. Have your staff warn patients that you are running behind. It smoothes a lot of ruffled feathers.**
- **Never let a day pass unless at least 1 patient without health insurance is seen by each physician in the Texas Medical Association.**
- **Our first responsibility is to our patients, who must receive timely, appropriate medical care with consideration for their privacy, dignity, and informed consent.**

Please send your suggestions for putting patients first and improving patient-physician communication to president@texmed.org.

Forum On Ethics

Genetics: manipulating Mother Nature

By Raymond Lewandowski, Jr, MD

Many people are concerned about what may happen when the computer codes that control most of society's logistics react to the calendar turning over to "00." Clearly, man-made computer codes are imperfect, and though the Y2K (year 2000) problem may be resolved, coding most assuredly will remain imperfect and require continuous update and repair.

Although the human genetic code is not man-made, it, too, contains errors. And man now has, and will continue to develop, methodologies to repair it. Through genetic research, we have gene therapy, cloning, and other technological advances that will change dramatically the face of medicine in the year 2000 and beyond. Our ability to manipulate our own genetic code will grow as public and private organizations commit significant amounts of money to completely unravel human DNA, and even patent it.

On the one hand, there is debate as to whether physicians and scientists should even be allowed to fiddle with Mother Nature and mold humankind at its most basic level. On the other hand, my patients ask me daily to be tested or treated for diseases, having heard the results of another genetic study reported by the media.

For most people, whether or not we should use gene therapy to cure disease is not a contentious issue. When arguments against gene therapy do arise, however, I have to ask how altering mankind's genetic code to cure severe diseases and perhaps increase life expectancy is any different from other measures medicine has taken to eliminate diseases such as diphtheria, polio, and tetanus. As we better understand our genetic code and become more proficient in gene therapy, physicians will be blessed with the ability to eliminate diseases such as cystic fibrosis, muscular dystrophy, and sickle cell anemia. We also will be able to significantly alter diseases that affect large segments of the population, such as cancer, diabetes, and cardiovascular disease.

While the identification of genes marches on, the mechanics of gene therapy have yet to be perfected. The largest single hurdle today is how to deliver a normal gene to an organ for it to do its job. This problem will no doubt be solved; theoretically, we then will be able to deliver any gene to any organ to alter an individual's genetic makeup.

But we still don't understand what the use of gene therapy to cure disease will do to the gene frequency for these disorders in the general population. The way gene therapy will cure disease is by introducing a new, normal gene at the somatic level, not by eliminating or changing the abnormal gene. This would cause the frequency of abnormal genes in the population to increase through gene therapy. Persons who would otherwise die from their diseases, or at least not reproduce, could survive and reproduce to transmit their abnormal genes to succeeding generations.

Human health and huge amounts of money are at stake, and we will learn the answers to these questions along the way.

Currently, the average individual carries 6 to 12 abnormal genes. If that load increases, what adverse consequences will befall the general population? Can we afford to wait and attempt to answer that question before proceeding? At this rate, there will be no waiting. Human health and huge amounts of money are at stake, and we will learn the answers to these questions along the way.

The medicine of genetics is in many respects the same as any other specialty. One clear difference, however, is the speed at which research is moving toward potential treatments. New, proposed

Raymond Lewandowski, Jr, MD, fellow of the American College of Medical Genetics and diplomat of the American Board of Medical Genetics, heads the Center for Genetic Services in Corpus Christi.

Texas Medicine welcomes comments about issues discussed in the Forum on Ethics. If you would like to comment or submit a column for possible publication, please contact Teri Moran, senior editor, at *Texas Medicine*, 401 W 15th St, Austin, TX 78701; phone (800) 880-1300, ext 1371, or (512) 370-1371; fax (512) 370-1632; or e-mail teri_m@texmed.org. Proposed columns must be no longer than 900 words and written in a case study format.

treatments currently undergo critical peer review and stringently controlled clinical trials before being released for broad usage. And because of these controls, physicians can feel confident about using gene therapy to provide their patients the best and most appropriate care.

In an era when American Medical Association articles are discussed in daily newspapers before the journals even reach their physician audiences, there is no doubt that public and bureaucratic opinion will help shape how we use our newfound capabilities. Although society undoubtedly will influence ethical decisions brought to the forefront by the study of genetics, I hope that the rigors of science and the ethics of medicine will keep us on course and true to our cause — providing the best patient care. ★

DCMS, alliance throw free health fair

Dallas area residents needing free health care screenings, immunizations, and health education should attend Health Check 1999, sponsored by the Dallas County Medical Society (DCMS), the DCMS Alliance, and *The Dallas Morning News.*

Health Check 1999 will be held on Saturday, February 20, from 10 am to 6 pm, and on Sunday, February 21, from noon to 6 pm, at the North Park Shopping Center on the southwest corner of the intersection of Northwest Highway and Central Expressway in Dallas.

This year's free health care screenings include checks on cholesterol level, blood pressure, glaucoma pressure, blood sugar level, HIV, cancer, body fat, children's vision, eating disorders, nutrition, stress, Alzheimer's disease, arthritis, chemical dependency, visual acuity, and dental health. This year's event will feature more than 150 booths operated by area medical centers, hospitals, physicians, and other health-related organizations.

For more information, call (972) 644-9505 or (214) 948-3622. ★

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TexMed program focuses on cancer prevention, detection

TexMed '99 attendees have a chance to learn important and timely cancer information from Texas' cancer experts while earning continuing medical education credit in ethics.

"Cancer: What Primary Care Physicians Need to Know," a symposium sponsored by Texas Medical Association's Committee on Cancer and TMA's Physician Oncology Education Program, will be held May 8, 1999, from 9 am to 5 pm at the Wyndham Anatole Hotel in Dallas. The symposium covers topics such as follow-up surveillance of cancer patients, ethical issues in assuring quality of life for cancer patients, genetic evaluation for inherited cancers, and smoking cessation techniques. Attendees also will hear presentations on colon cancer screening, prostate cancer detection, chemoprevention in breast cancer, and screening intervention for gynecologic malignancies.

To reserve your place at the symposium, check "Cancer: What Primary Care Physicians Need to Know" on your TexMed '99 registration form. For more information, contact Leslie Jones at (800) 880-1300, ext 1671, or (512) 370-1671; or e-mail poep@texmed.org. ★

Live & Then Give earns golden ASAE award

The Live & Then Give organ donor awareness campaign recently received a Gold Circle Award from the American Society of Association Executives (ASAE). Live & Then Give took the top prize over more than 30 other entries in ASAE's Public Relations/Informational Campaign for a Single Purpose category.

Leslie Tate, director of programs for the Texas Medical Association Alliance, accepted the award at the ASAE Meeting and Technology Conference in Washington, DC, last month. ★

Students, community fund new UT-Houston building

The dream of a new nursing and biomedical sciences building at The University of Texas-Houston Health Science Center has nearly become reality, thanks to student fees and contributions from Houston philanthropic foundations, corporations, and individuals.

Out of the $60 million cost of the building, only $2 million more needs to be raised, according to UT-Houston President M. David Low, MD, PhD. "This 220,000-square-foot building, designed by competition-winning Patkau Architects of Vancouver, British Columbia, will be both a center for our student services and a tribute to the selfless commitment and dedication of UT-Houston's wonderful students, who have agreed to shoulder one third of the cost through the staged increase of the general use fee," Dr Low said. "The students' willingness to contribute to the construction of this building has helped with local fundraising in the Houston community."

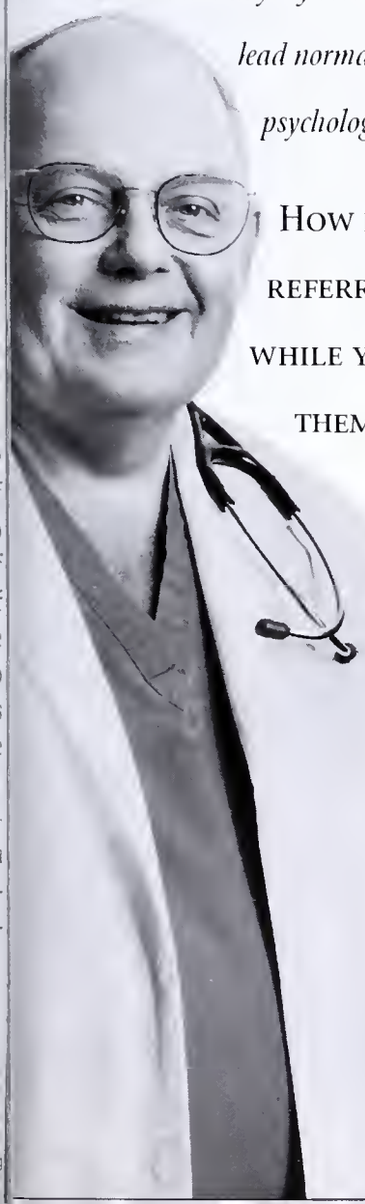
The new building, slated for occupancy in 2002, will be constructed on a narrow site at the intersection of Holcombe and Bertner next to the UT-Houston School of Public Health. ★

Making A World Of Difference For The Referring Physician: Cook Children's Talks With Dr. Paul Gillette.

DR. PAUL GILLETTE — MEDICAL DIRECTOR OF PEDIATRIC CARDIOLOGY

.. GILLETTE, YOU PIONEERED RADIO FREQUENCY LATION. IT'S WELL KNOWN THAT PATIENTS COME OM AROUND THE COUNTRY AND ALL OVER THE ORLD FOR YOUR EXPERTISE. HOW DOES THIS OCEDURE HELP KIDS?

lio frequency ablation allows us to treat children with serious liac arrhythmia. It lets us correct the fast heartbeat using a very risk procedure, one that requires only a 24-hour hospital stay, about two to three days of recovery. These kids can go on to lead normal lives, which has a tremendous psychological benefit as well.



HOW DO YOU WORK WITH REFERRING PHYSICIANS SO THAT, WHILE YOU ARE A RESOURCE TO THEM, YOU DON'T COME ACROSS AS TRYING TO DIMINISH THEIR OWN RELATIONSHIP WITH THEIR PATIENTS?

We make sure we stay in touch with the referring physician at all times. For example, we fax them a handwritten report the same day we perform ablation. In addition, since a lot of our patients come from out of town, we travel to other cities to get to know the primary care doctors.

WHAT DO REFERRING PHYSICIANS THINK ARE THE KEYS TO EXCELLENT PEDIATRIC SPECIALTY CARE?

They want a cure, which isn't always possible, but they know we'll do everything in our power. They know we have their patients' best interests at heart.

CAN YOU RELATE AN INTERESTING CASE WHICH EXEMPLIFIES THE TRUST OF REFERRING PHYSICIANS IN YOUR SPECIALTY CARE HERE AT COOK CHILDREN'S?

Well, there have been quite a few interesting and rewarding cases. Children who suffer from cardiac arrhythmia come to us from all over the globe, and the radio frequency ablation procedure lets us correct about 90% of the problems we see. We get to send a lot of kids back home very healthy, very happy.

Cook Children's Medical Center is located in Fort Worth, Texas. For more information about Dr. Gillette and our other doctors of Cardiology — J. Hudson Allender, Christopher L. Case, Susan Hess, Stephen Lai, Daniel Miga, Richard Readinger and Matthew M. Weinecke, call 1-800-COOK517.

CookChildren's
Medical Center

REPUBLIC OF TEXAS

The Texas legislative session that convenes January 12 likely will not be dominated by a single, high-profile health care issue such as the precedent-setting managed care reforms enacted in 1997 or, for that matter, the sweeping tort reforms of 1995. But political observers and TMA physician leaders say the 76th Texas Legislature will provide tremendous opportunities for health care, ranging from additional, if more modest, managed care reform to "sunset" review of the state's major public health agencies to how Texas will spend the first $2 billion of its huge tobacco lawsuit settlement. ➤➤

Organized medicine's agenda will be lengthy and more complex than in previous sessions. Already, intense negotiating sessions are under way on technical issues such as claims processing, financial incentives, and risk contracts. Fights are brewing over issues such as physician profiling and optometrists' scope of practice. And the sunset process will virtually guarantee House and Senate floor fights on controversial issues such as school health funding, family planning, and abortion.

"This session really is going to test the mettle of all the coalition-building the Texas Medical Association has done in the past because there are so many diverse issues this year," said Fort Worth surgeon Robert W. Sloane, Jr, MD, chair of TMA's Council on Legislation. "That means we may have different allies in one arena and then we move to another arena and find a different set of allies, be they business groups, other providers, or regulatory agencies. It will be a difficult session."

Still, continuing cooperation between TMA and several allied health groups means many scope-of-practice fights may be avoided. Those groups, along with consumer advocates and others, are forming alliances to ensure that the big infusion of cash from the tobacco settlement is used to benefit health care. Meanwhile, advocates for highways, education, prisons, welfare, and countless other issues will try to carve out some of that money for their pet projects.

While the session seems ripe for controversy, these issues all will play out in a political environment in which lawmakers will be highly motivated to avoid controversy.

Playing it safe

"This is a legislature that's going to be very risk averse," said Kim Ross, TMA's vice president for public policy. "These are the legislators that will run for reelection [in 2000] based on their records in this session. Those lawmakers in turn will make up the redistricting legislature that draws new district boundaries and determines the proportionate representation of this state by party into the next millennium and for a very long time thereafter."

Consequently, Mr Ross says, both House and Senate leaders likely will make concerted efforts to resolve the tougher issues in committees and avoid ugly floor fights that might produce "gotcha votes" that political opponents can use to tag a legislator as an extremist or a big spender, thereby hurting his or her reelection chances.

"This session really is going to test the mettle of all the coalition-building the Texas Medical Association has done in the past because there are so many diverse issues this year."

Republican revolution

Adding to the tense political environment will be the increasing Republican inroads into a previously Democratic stronghold. Republicans already hold a slim 1-vote majority in the Senate, where a Republican lieutenant governor will preside for the first time since Reconstruction. And, the Democratic majority in the House was cut to 8 in the November general election.

That, Mr Ross says, means the race to determine the next House speaker in 2001 could begin this session and challenge the formidable skills of current Speaker Pete Laney (D-Hale Center) to keep the wheels of the House rolling in the same direction.

"There are 5 or 6 members who think they can be the next speaker or can be the broker to deliver the votes to decide the next speaker. They each have 5 to 10 votes," Mr Ross said. "So you'll see voting patterns this session where some factions will vote against other factions just because they're on opposite sides of the speaker's race. Those votes will be irrelevant to the policy question before them."

Within that political environment, here is how the major health care issues likely will play out.

Managed care

Medicine's victories on patient protection issues were so sweeping in 1997 that this year's objectives can't help but be more modest.

"There likely will be little activity regarding patient protections," said TMA lobbyist Connie Barron. "With Texas leading the nation in these reforms, we need to educate consumers and support enforcement of the current laws and regulations."

One exception is in the area of financial incentives. The 1997 reforms prohibit any financial incentive intended to induce the delay or denial of medically appropriate care. However, they do not spell out exactly what types of incentives fall under that category, and in November then-Insurance Commissioner Elton Bomer dropped plans to draft guidelines on incentives despite months of public hearings and negotiations. That means an attempt may be made to get lawmakers to clarify the statute.

Beyond that, medicine's stance on managed care issues may be more defensive. Managed care entities are facing severe cost pressures and are running out of ways to protect their bottom line, says Mr Ross. With their defeat in the patient protection arena, they are trying increasingly to drive out competition from physician networks, pit networks against each other, demand tough "all products or nothing" contracts with physicians, and continue to drag out the claims payment process.

One issue is the question of regulating physician-directed networks. Ms Barron says Mr Bomer and some lawmakers have expressed interest in regulating entities that assume some level of financial risk. That interest grew, in part, out of the bankruptcy last year of FPA Medical Management, Inc, a physician practice management company.

TMA supports the development of more physician-directed entities, says Rich Johnson, director of TMA's Division of Medical Economics. The large health maintenance organizations (HMOs), however, want to place tough regulations, including large capital reserve requirements, on physician-directed entities to reduce their competition. Such regulations likely would eliminate many physician-directed entities.

The TMA Ad Hoc Committee on Physician Networks is developing options for regulations that would balance patient protections with flexibility to allow the physician networks to evolve.

Mr Johnson says the same cost pressures alluded to by Mr Ross are driving the merger trend among the large managed care companies, a trend he says may leave only 3 or 4 huge HMOs in the marketplace.

"The continuing mergers and consolidations are creating a lot of competition for market share and pressure on the managed care companies to hold onto dollars as long as they can," Mr Johnson said. Intentional efforts to slow down claims payment, or data processing confusion resulting from the mergers, may force an effort to define by law what constitutes a clean claim and to set stricter time limits for claims payment.

Numerous other managed care issues also are being driven by these market forces, ongoing efforts of the HMOs to hold down prescription drug benefits through formularies and the use of pharmacy benefit managers (PBMs), and intrusions into medical privacy by PBMs, managed care entities, and employers.

Mandated benefits

While those issues are playing out on the physicians' side of managed care, employers have a managed care agenda of their own. The Texas Association of Business & Chambers of Commerce (TABCC) has made mandated insurance benefits its top issue. TABCC wants a moratorium on any insurance mandates and, possibly, the rollback of some existing mandates.

"It is unlikely that a repeal of mandated benefits or a full moratorium is politically viable," Ms Barron said. "However, there likely will be some type of 'process' legislation that will require that certain information regarding cost and efficacy be provided prior to the passage of any new benefits."

"The continuing mergers and consolidations are creating a lot of competition for market share and pressure on the managed care companies to hold onto dollars as long as they can."

Another issue employers likely will want to revisit from 1997 is physician profiling. Consumer groups and TMA negotiated a bill in 1997 that would have consolidated and made available from one source — the Texas Health Care Information Council (THCIC) — existing physician profile data, such as medical school training, specialty, board certification, disciplinary actions by the Texas State Board of Medical Examiners (TSBME), and other public information.

Employers, however, may seek to give THCIC authority to collect even more information, such as physician-specific outcome data and hospital morbidity and mortality rates.

"The rush is on for more information, ostensibly to make the market more efficient and more competitive," Mr Ross said.

But Waco internist Joe H. Cunningham, MD, says more data won't necessarily tell employers who the good and bad physicians are. Dr Cunningham, who chairs 1 of the 3 TMA Council on Legislation subcommittees reviewing likely issues for the upcoming session, says raw data on physician outcomes will be skewed heavily against the doctors who treat the sickest patients, possibly making them hesitant to take on difficult cases.

Scope of practice

One issue that perennially finds its way onto the legislature's agenda is an effort by allied health professionals to expand their scope of practice into areas reserved traditionally for physicians. This session will be no exception.

Alfred Gilchrist, TMA's legislative affairs director, says scope-of-practice battles already are anticipated with optometrists over authority to treat glaucoma, physical therapists over direct access to patients, and acupuncturists over independent practice and creation of their own licensing board. Acupuncturists currently are regulated by TSBME.

Dr Cunningham says a similar battle could develop with certified registered nurse anesthetists, depending on the outcome of a pending attorney general's opinion involving hospital credentialing.

Dr Cunningham, however, says he does not anticipate scope-of-practice fights to develop with nurses, physician assistants, or other allied health groups mainly because of an Ad Hoc Council on Collaborative Practice that was initiated several years ago. That group, which includes representatives of TMA, the Texas Nurses Association, the Texas Academy of Physician Assistants, and the Coalition for Nurses in Advance Practice, has been meeting between legislative sessions to resolve disputes involving collaborative practice.

Jim Willmann, general counsel and governmental affairs director for the Texas Nurses Association, also sees little potential for legislative fights between physicians and nurses. He says the cooperation fostered by the ad hoc council is extending to issues beyond scope of practice, such as mutual support for the Children's Health Insurance Program and development of a coalition to support cardiovascular disease recommendations released by a special House subcommittee on that issue.

Added Mr Gilchrist, "There is more opportunity for cooperation on public health, managed care, Medicaid fees, and workers' compensation issues than we've seen in recent memory. We are going to encourage other health professionals to work with us in those areas. But for those who want to try to expand their scope into the realm of medical practice, we're going to draw a hard line in the sand."

Mr Gilchrist says there is another area of newfound cooperation likely to appear this session. That is with pharmacists who are looking to make a dramatic change in their role in the health care delivery system.

"The pharmacists are going to fight in every legislature across the country to redefine themselves," Mr Gilchrist said. Pharmacists want to work with physicians to manage certain diseases, such as diabetes, hypertension, and asthma.

"TMA is 1 of only 2 or 3 medical associations in the country that has a liaison committee with the pharmacy association, through which the pharmacists are actually laying out their vision of pharmacy care to physicians and asking for their input," Mr Gilchrist said. "In Mississippi, Idaho, and a number of other states, that communication does not exist and there's a great deal of fighting between the 2 professions."

The physicians on TMA's liaison committee also are pharmacists, so they see the issue from both perspectives, Mr Gilchrist says. They are working collaboratively with the pharmacy representatives to avoid the antagonism that exists elsewhere. This collaboration likely will help avoid a scope-of-practice fight this session and may lead to an appropriations request to fund a pilot project examining the changing role of pharmacy, as well as leading to cooperation on some managed care issues.

In fact, some physicians and pharmacists already are working collaboratively under current state law to do just that, with the pharmacist providing patient education and monitoring medication compliance. Mr Gilchrist says at least one physician who has spoken to the committee reports better medication compliance among patients who work with a pharmacist in his office.

Public health systems

One of the more contentious legislative debates will focus on the effort to reauthorize the state's major public health agencies through the sunset process. Fifteen health and human services agencies ranging from large agencies such as the Texas Department of Health (TDH) and Department of Mental Health and Mental Retardation to small agencies like the Center for Rural Health Initiatives will undergo sunset review this year.

"We are going to encourage other health professionals to work with us in those areas. But for those who want to try to expand their scope into the realm of medical practice, we're going to draw a hard line in the sand."

The sunset review process has been under way for months and the Sunset Commission already has issued several recommendations, including suggestions that TDH create a centralized access point for its health statistics and study the adequacy of its computer system to handle the Medicaid managed care program.

One controversial recommendation from the commission staff would give the Health and Human Services Commission additional oversight power over other health agencies under review.

However, Mr Ross says the real controversy from sunset review likely will come from the opportunity the process provides to carry out agendas only tangentially related to reauthorization of the agencies. "This is a once every 12 years opportunity when you have a germane caption on the floor of both chambers," he said. "The sunset process will make Austin look more like Beirut before it's over because the sunset process is also about hostage taking."

Legislative rules prohibit adding an amendment to any bill unless the subject of the amendment is germane to the caption of the bill. The broad captions of the sunset bill for each agency, however, will open up those bills to a wide array of health-related issues.

"No one is going to sunset the state department of health," Mr Ross said. "That means every gatekeeper in this game, of which there are many, can hold up that agency and not let it move through committee or to the House or Senate floor until his or her agenda is attached, be it school health funding or regulation of abortion facilities or something else."

Mr Gilchrist says TMA's priority in these sunset battles will be to ensure the public health infrastructure of the state is protected and any attempt to weaken it defeated.

Dozens of additional health-related issues will appear on the legislative radar screen this session. Mr Gilchrist says TMA will ask lawmakers to look at Medicaid physician fees, which have been frozen for several years. TMA lobbyist Harold Freeman says there also will be efforts to create a medical director position at the Texas Workers' Compensation Commission and to tighten the cost bond and expert affidavit provisions of the 1995 medical liability reforms. Some judges aren't strictly enforcing those provisions, he says.

Tobacco dollars

The legislature's single greatest opportunity to make a mark this year in the health arena, however, may be its deliberations on how to allocate the tobacco lawsuit money. The tobacco industry paid its first installment on the $17 billion settlement late in 1998. That money will be available for appropriation this year. (See "Do the Right Thing," pp 34-38.)

"We have a historic opportunity for the legislature to make lasting advances in public health, research, and access because of the tobacco settlement," Mr Gilchrist said. "We believe that was a health care lawsuit and that the money ought to go back into health care."

While there initially was a high-profile debate over how then-Atty Gen Dan Morales proposed to distribute those funds, key House and Senate budget writers entered into an agreement with Mr Morales to try to preserve that money for health care needs in this year's appropriations process. That agreement includes appropriating $151 million for the Children's Health Insurance Program, $200 million for antismoking activities, $200 million to establish a children's cancer center at The University of Texas Health Science Center at San Antonio, and smaller endowments for most of the state's other medical schools. In mid-November, the Senate Interim Committee on Children's Health Insurance, the House Committee on Public Health, and the House Appropriations Committee voted unanimously to recommend that the state spend $151 million a year to draw down additional federal funds.

Although both Senate Finance Committee Chair Bill Ratliff (R-Mount Pleasant) and Appropriations Committee Chair Rob Junell (D-San Angelo) have agreed to include all those items in the appropriations bill they file, there is no guarantee they will remain in the bill. Mr Gilchrist says there will be considerable competition from nearly every special interest group to grab part of that money. Representative Junell, at least, is on record saying he believes the tobacco money should be used to meet the state's health care needs.

> "This is a once every 12 years opportunity ... The sunset process will make Austin look more like Beirut before it's over because the sunset process is also about hostage taking."

Knowing there would be fierce competition for the new dollars from all sources and that it was likely some parts of the agreement would not be funded, TMA put together an advisory committee to examine the state's health care needs and make recommendations for funding priorities. The committee presented its report to the TMA House of Delegates in November. The report recommends myriad health care-related options legislators may choose. Dr Sloane says he would like to see the money placed into an endowment fund that would earn income and from which grants could be made for a variety of health programs. However it is used, it must be safeguarded for health care, he says.

"I really think it's paramount that the tobacco money be held aside as health related," he said. ★

Do the right thing

Will the tobacco money be spent on health care?

Ibid

It's been a year since then-Atty Gen Dan Morales won for Texas the largest chunk of change ever awarded in litigation history. Mr Morales secured a $15.3 billion settlement — which eventually grew to $17.3 billion — in the state's lawsuit against the tobacco industry. The settlement money will be paid out over 25 years, and it is now up to the Texas Legislature to decide how to spend the first year's installment. The big question is, what will lawmakers do with it?

By Teri Moran, Senior editor

Health care advocates want it spent on public health, with priority given to improving children's health and raising the state's sickly rankings on health issues. But they fear a special-interest feeding frenzy at the State Capitol when the legislature convenes this month may fritter away the money.

Mr Morales says he sued Big Tobacco because it lied for years about the dangers of smoking and should be required to pay some portion of what Texas has spent on sick tobacco users.

His victory surprised just about everyone. Big Tobacco had long been an impenetrable force, a Goliath on a hill accustomed to soundly defeating any challengers to its practices.

And when Mr Morales secured the settlement, Texas suddenly had an almost unfathomable amount of money in its general revenue fund, which is not earmarked for anything specific. Mr Morales proceeded to direct the money toward children's health and other health programs, saying last January that from day 1 his goal in holding the tobacco industry accountable for its actions was to "protect and improve the public health, especially in regard to our youth."

Lawmakers, however, contended that deciding how the money would be spent was their job, not the attorney general's, and they went to court to wrest control from him. Mr Morales' efforts to win money for the state's health programs could have been lost then, but he was able to make a deal with the 2 men who exert significant control over the state's purse strings: Senate Finance Committee Chair Bill Ratliff (R-Mount Pleasant) and House Appropriations Committee Chair Rob Junell (D-San Angelo).

Senator Ratliff and Representative Junell signed a Memorandum of Understanding (MOU) with Mr Morales that directs $881 million of the first $1.2 billion installment to specific public health programs (see "The heart of the Memorandum of Understanding," p 36). The agreement also says Senator Ratliff and Representative Junell will try their best in the 1999 session to direct the rest of the first installment into 2 permanent endowment funds — 1 for children's health and 1 for higher medical education.

Although the MOU doesn't bear the weight of law and doesn't apply to future tobacco installments, Senator Ratliff seems confident Representative Junell and he will be able to fulfill its intent. "I think we'll be able to keep virtually all of it earmarked for health or medicine in some manner. I haven't had one legislator express disagreement that it all ought to go to health care." Keeping it from being "nickeled-and-dimed" away from where it can have some real impact will be their challenge, he adds.

idea how bad Texas' public health problems really are. "Texas takes care of its middle class and its rich better than anybody else in the world," Dr Cunningham said. "But there is a level of society that doesn't get the benefits of our health care system, and it includes a lot of working families. They don't have access and they don't have education, and the effect that will have on the future for all of us is just devastating. Unhealthy kids can't learn, and they end up being a drain on society their whole lives."

"I think we'll be able to keep virtually all of it earmarked for health or medicine in some manner. I haven't had one legislator express disagreement that it all ought to go to health care."

Invisible problem?

Still, some health care experts will hold their breath until they see it in writing. Texas' pitiable rankings compared with other states in many public health measures fill pages. But one of the most disturbing problems is the high number of Texans, especially children, who lack adequate access to care. The Texas Medical Association commissioned a report on the health status of Texans, which showed that:

- An estimated 1 in 4 Texas children (1.3 million younger than 18) do not have health insurance.
- 750,000 Texas kids, most of whom live above the federal poverty level and who have working parents, were added to the list of uninsured children between 1995 and 1996, according to the Census Bureau.
- In 1997, Texas tied with Arizona for having the greatest proportion of uninsured residents of the 50 states.
- In 1997, approximately 4.6 million Texans (24.5%) were uninsured, compared with 16.1% in the United States.

Waco internist Joe H. Cunningham, MD, who served on TMA's Ad Hoc Committee for Tobacco Funds, believes most middle- to upper-class people have no

Senator Ratliff admits he doesn't really know how extensive the problem of uninsured children really is, but says it makes economic sense to fund efforts to get them better primary care. "The public pays to take care of these kids anyway because they wind up in the emergency room, which is the most expensive setting. To me, a part of the decision facing this legislature is purely pragmatic. If we can take care of these children before their illnesses or maladies get out of hand, we'll save money."

Billions directly to counties

Traditionally, there has been a measure of fluff in the health care system to cover many of the costs of providing indigent care. But in the last few years, that fluff has all but disappeared. Local health departments all over the state are reorganizing and trying to push many of the services they provide onto hospitals and other providers, Dr Cunningham says. "With the onset of managed care coinciding with this, that extra money to take care of indigent people is going down."

Dr Cunningham is concerned that Texas counties will use the tobacco money on filling potholes, not on indigent care. "Many counties may not see the long-term importance of spending money on health care because they

weren't involved in the whole process. There's been a disconnection there."

Counties and hospital districts ultimately will have $2.275 billion to divvy up among themselves, starting with a $300 million payment January 1. Mr Morales won these extra billions on top of the original $15.3 billion award by negotiating an enhanced deal last summer when Minnesota subsequently won more favorable terms than Texas did originally in its settlement with the tobacco industry.

The first $300 million lump sum to counties has no strings attached. Counties technically may spend it any way they want. But subsequent payments will be on a pro rata basis, meaning that to get more money for indigent care, they'll have to spend money on indigent care.

Senator Ratliff says he can't micromanage how counties spend that money. "During some years, counties have been required to spend money for indigent health care. They may be thinking that they've been providing that care out of their budgets and now want to replace it. I'm not going to make that decision for them. But in future years, the money will go to them proportionately based on how much they spend for indigent care."

Dr Cunningham urges Texas physicians to call their county commissioners and judges and make personal appointments to educate them on the need to spend the money on public health. "The assumption is that hospitals and doctors will always be able to take care of these people. But it's becoming increasingly difficult. The margins are too small. The forces of managed care have taken away that safety net. That extra money is going to health maintenance organizations, and they are not doing any indigent care."

If worse comes to worse

Because the terms of the MOU, even if accepted by the legislature, only last one legislative session, TMA formed the Ad Hoc Committee on Tobacco Funds last year to coordinate the association's policy and strategy. One of the committee's goals was to show

The heart of the Memorandum of Understanding

On February 3, 1998, Sen Bill Ratliff (R-Mount Pleasant), Rep Rob Junell (D-San Angelo), and Atty Gen Dan Morales signed a Memorandum of Understanding (MOU) to avoid a protracted legal struggle for control of the tobacco settlement.

The parties agreed to use their best efforts to facilitate the transfer of funds to begin implementation of the Children's Health Insurance Program (CHIP) and the tobacco pilot project.

They also agreed to include the following provisions in the general appropriations bill for the 76th Legislature, in addition to any necessary enabling legislation:

- **$151 million for CHIP.**
- **$200 million to fund the tobacco pilot program, a project to support smoking cessation programs, enforcement of juvenile smoking laws, counter-marketing promotional efforts directed toward youth, general antitobacco educational programs, and other similar initiatives.**
- **$200 million to The University of Texas Health Science Center in San Antonio to operate and fund the Texas Children's Cancer Institute.**
- **$100 million to The University of Texas M.D. Anderson Cancer Center in Houston.**
- **$50 million to Texas Tech Health Sciences Center in Lubbock for border health issues.**

The MOU says the money should be used to create endowment funds for research and other programs that benefit public health in these amounts at the following medical schools:

- **$50 million to The University of Texas Southwestern Medical Center at Dallas.**
- **$25 million to The University of Texas Medical Branch at Galveston.**
- **$25 million to The University of Texas-Houston Health Science Center.**
- **$25 million to The University of Texas Health Center at Tyler.**
- **$25 million to the Texas A&M University Health Science Center.**
- **$25 million to the University of North Texas Health Science Center at Fort Worth.**
- **$25 million to the Regional Academic Health Center (upcoming in the lower Rio Grande Valley's largest cities).**

The parties agreed that any remaining 1998 funds should be spent on the following:

- **Permanent Fund for Children and Public Health to provide a perpetual source of funding for children's programs and public health services.**
- **Permanent Health Fund for Higher Education to provide permanent financial support for medical research, health education, and treatment programs at the public health-related institutions of higher education.**

legislators other health care needs in the state that could be funded if for some reason they choose not to implement the MOU.

During its interim session in November, TMA's House of Delegates agreed with the ad hoc committee's recommendation that all the settlement dollars should be dedicated to improving the health of all Texans, including direct medical care, prevention, and research, and that a majority of the funds should be allocated to patient care for tobacco-related illnesses.

> "The forces of managed care have taken away that safety net. That extra money is going to health maintenance organizations, and they are not doing any indigent care."

The House voted to officially applaud Mr Morales, Senator Ratliff, Representative Junell, and other legislators for negotiating the MOU.

Some elements of the committee's report also are found in the MOU. The committee recommended funding:

- Public health infrastructure.
- Uninsured children through the Children's Health Insurance Program (CHIP).
- An income-generating fund to fight tobacco use in Texas.
- An endowment fund for public health programs.
- Creation of the nonprofit Texas Foundation for Children and Public Health with 20% of the tobacco settlement money to fund programs on childhood immunizations, prenatal care, health education, and substance abuse. (This was one of Mr Morales' top priorities and was included in the MOU.)
- Efforts to complete US-Mexico Border Health Commission goals.
- Establishment of a council dedicated to reducing cardiovascular disease and stroke.
- Development of a statewide strategy and system to control infectious and reemerging infectious diseases.
- Formation of a coordinated statewide emergency medical system/trauma system.
- A permanent endowment fund for Texas medical schools for curriculum development and research, with a special emphasis on tobacco-related illnesses, public health education, and delivery of care.

Creating the children and public health foundation would allow community groups to apply for grants to fund their own local programs, based upon the assumption that social change is more likely to succeed when those who will be affected are involved in planning, initiating, and promoting the change. "The examples of ways communities could get involved to better children's health and public health abound," said Robert Emmick, MD, of Bryan, who served on the statewide Inter-Agency Tobacco Task Force (see "Task force develops $200 million prevention program").

Task force develops $200 million prevention program

The Texas Medical Association participated last year in the Inter-Agency Tobacco Task Force at the invitation of Commissioner of Health William R. Archer III, MD. Then-TMA President Phil H. Berry, Jr, MD, designated Nick Curry, MD, of Manor, and Robert Emmick, MD, of Bryan, to represent the association.

The task force, consisting of a dozen health care groups and agencies, developed a plan to present to the 1999 Legislature. The plan is designed to target youth tobacco use, protect the public from involuntary exposure, and eliminate disparities among diverse and special population groups. TMA's House of Delegates approved the plan in November.

Using the $200 million designated for tobacco prevention in the tobacco settlement, the plan includes the following elements:

- **Community and local coalitions as well as projects involving school-based youth and parent programs to address societal environment changes related to tobacco use.**
- **A public awareness campaign and media resource center to promote tobacco use prevention and cessation, and protection from secondhand smoke.**
- **An effective state cessation and treatment program involving the establishment of a free bilingual, multiethnic telephone quit line.**
- **Development of an ethnic tobacco education network in rural Texas areas that would involve diverse and special population community leaders in education, prevention, policy, and advocacy efforts.**
- **Surveillance, evaluation, and research to monitor the impact of program components on the environment and the population.**
- **Enforcement of public policies that restrict access to and possession of tobacco products by youths.**
- **Staff to coordinate the statewide program.**

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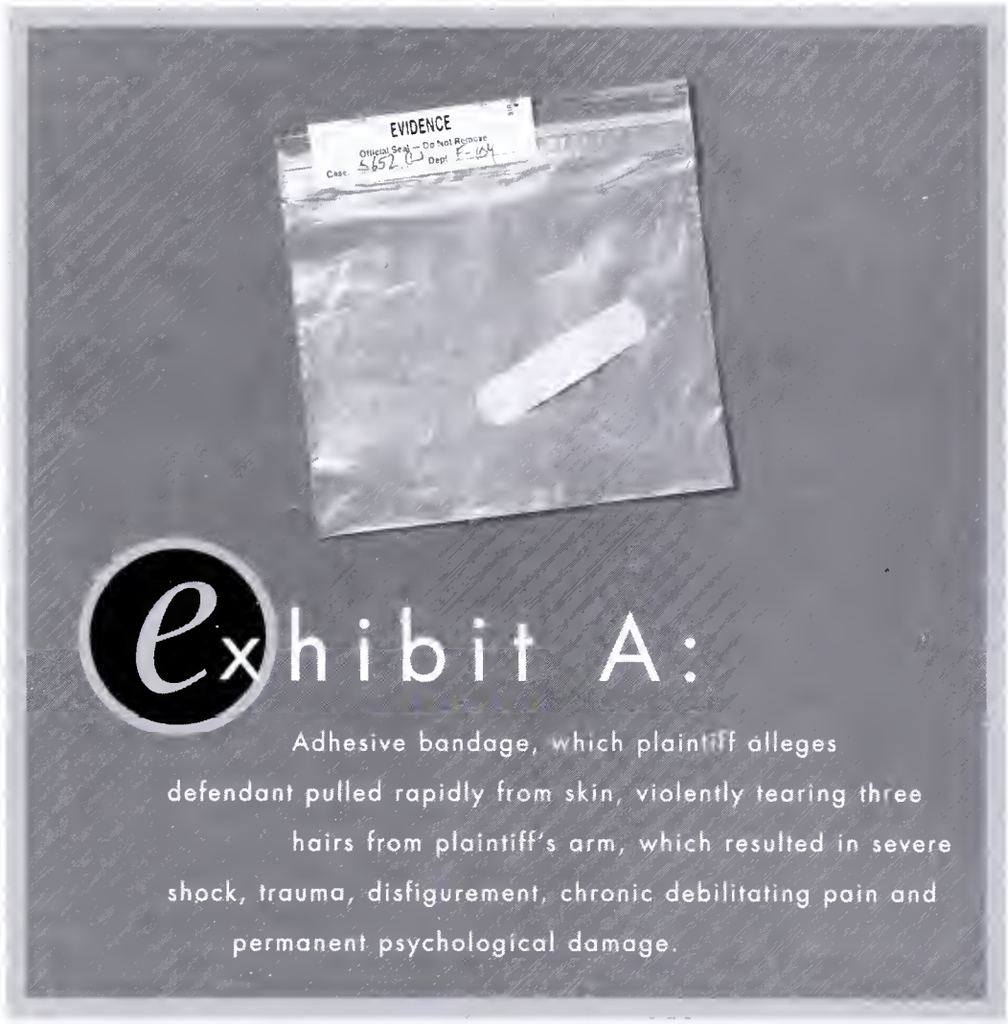

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No better time

Aging baby boomers will soon add an additional burden on a health care system that already is strained financially, taking Texas' budget surplus along with it, Dr Cunningham says. "Now is our one opportunity to take care of our children. We need to act now and fund programs such as the Children's Health Insurance Program." Every $1 the state spends on CHIP will draw down 3 federal dollars.

Don Gilbert, the Texas commissioner of health and human services, agrees. "Texas has a historic opportunity to match sizable federal funds and implement a new program that can insure thousands of Texas children." He stresses that although it isn't his role to address the state's funding sources, he hopes any extra money will be spent on the most pressing health and human services needs through investment budgeting, which has "long-range dividends that are particularly beneficial in public health. One of the best ways we can effectively approach the budget process in Texas is through the wise investment of state dollars in prevention."

Many health care advocates have called the 76th Legislature's decisions about how to spend the tobacco billions a once-in-a-lifetime chance to leave a legacy for Texas. "It is just such an opportunity," Senator Ratliff said. "I don't think we'll leave a legacy if we just spend the money. Representative Junell and I are strong believers in putting as much money as possible in a permanent endowment similar to what Texas' founding fathers did with higher education and public education. Our children are benefiting from that today, more than 100 years later. If we use that pattern, we will leave a legacy that Texas children will benefit from for generations." ★

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Privileges primer

A few prudent steps can ease the pain of peer review

A license to practice medicine is a physician's most valued asset, followed closely by clinical privileges granted by hospitals, managed care entities, or other organizations. The threat of losing the latter is catastrophic enough, but it often can begin a slippery slope that imperils the former.

I have served as counsel to physicians in scores of credentialing, deselection, and "corrective action" procedures during the past 2 decades in just about every kind of practice environment. I have distilled the successes and mistakes I have both made and observed into a primer on how to protect your clinical privileges. ➤➤

By John B. Larrimer, JD

What's at stake

There was a time when a physician could change practice venues as easily as a good obstetrical nurse could change hospitals, but no longer. A negative corrective action event goes into the National Practitioner Data Bank for all to see, follows you forever, and makes any future granting of privileges an uphill battle, because you will have the burden of proof in any credentialing process. It also will increase your professional liability insurance rates and get thrown back in your face in any malpractice action against you.

The process

Medicine is perhaps the only profession today that self-polices by true peer review. And despite the occasional horror story of the 2 doctors in a small town getting together to run the third out, and the increasing pressures of "economic credentialing," it works. In the past, nobody was ever crass enough to say it outright, but when has credentialing *not* been "economic"?

A denial, reduction, or loss of clinical privileges can occur when you apply initially or when you apply for expanded or renewed privileges. Or, it can happen ad hoc, typically when a complaint arises from a patient, a fellow practitioner, or the administration (often based on the economic issue again).

Hospital bylaws throughout the country, particularly in their fair hearing plans, are becoming remarkably uniform in their provisions. The first step generally begins with the medical executive committee, which takes up recommendations from a credentials committee or receives a report of needed corrective action from another practitioner or perhaps another committee, such as the surgery and tissue committee. If the medical executive committee makes an adverse decision, the affected practitioner may request a hearing. These hearings are typically full-blown quasi-judicial proceedings that include lawyers for both sides, a court reporter, a presiding officer who acts as the judge, and a panel of 3 to 5 peer practitioners who serve as a jury and sit in judgment on your professional future. Many physicians, and, sadly, even a few lawyers believe this is where the defense of one's privileges begins. Nothing could be farther from the truth because in law, as in medicine, prevention is the best cure.

Heading off trouble

Many physicians faced with corrective action proceedings seem to have certain common characteristics that can be summed up in 6 words — an arrogant loner with poor documentation.

By "arrogant," I don't mean someone possessed of the healthy ego necessary for any professional who is daily called upon to make decisions of great import. Rather, I mean the kind of physician who exudes the attitude, "They're just jealous of me because I'm on the cutting edge, I'm getting all their patients, and they [especially the nursing staff and the anesthesiologists] are angry at me because I demand high standards and call them on their mistakes." Well, perhaps once upon a time, 2 small-town specialists convinced the hospital and the medical staff to gang up on a third and run him out of town so they could split his practice, but dengue fever epidemics in rural Montana occur more frequently. When I encounter the occasional physician client who gives that sort of explanation for his problem, he and I undertake a crash reeducation program. If that doesn't take, he gets another lawyer.

When I speak of a "loner," I don't mean a solo practitioner. I mean the guy who never asks for a consult, never has an assistant for complex or protracted surgeries, doesn't participate in medical staff committees or affairs, doesn't write thank-you notes for referrals, and does not make or follow up on referrals. This guy doesn't take every opportunity to compliment his peers on their successes or ask for their thoughts when he has doubts. You may be a loner if you have never handwritten a note to this effect: "Dear Bob, Thanks so much for your input on Mrs Smith's rectovesical fistula. Your suggestions really made a difference, and she's back riding her Harley."

And another thing, if you ever get even a hint that your practice is under investigation, try to get involved in the investigation as soon as possible. Be helpful. Point everyone in the right direction.

A negative corrective action event goes into the National Practitioner Data Bank for all to see, follows you forever, and makes any future granting of privileges an uphill battle.

And last, but far from least, is documentation. The beginning, middle, and end of every corrective action proceeding — and malpractice case, I might add — is chart review. If it's not in the chart, it did not happen. At a formal hearing 2 years down the road when you're asked why you didn't consider so-and-so, you won't be able to win the day by saying from memory, "Well, of course I considered so-and-so, but I ruled it out because of such-and-such." This causes the eyes of the hearing panel members to roll back into their heads, and it erodes your credibility.

It is unfortunate that so many physicians consider documentation to be an onerous, bureaucratically imposed adjunct to medical practice. As a lawyer, I'm not qualified to tell you that thorough charting is good medicine, but I am qualified to tell you that it's the best tool you have to defend yourself against criticism. And the more complex or controversial the diagnosis or procedure, the more thorough should be your documentation, with particular emphasis on whether a more conventional or low-risk approach was ruled out and why. Clear. Concise. Legible. Contemporaneous with the events. Again, if it's not in the chart, you have a heavy burden to prove that it happened.

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Forget fair play

Hospital bylaws have become peer review traps

Many physicians probably don't realize that for peer review proceedings, some hospitals have 2 sets of bylaws — one set adopted by the board of trustees and another adopted by the medical staff. A physician's due process rights in peer review typically are contained in medical staff bylaws; however, unless the hospital trustees agree to be bound by medical staff bylaws, there may be little protection for the physician. In *Weary v Baylor University Hospital* (1), a physician was not reappointed to the staff and was denied a hearing that was guaranteed in the medical staff bylaws. The hospital successfully argued that this right to a hearing was contained in medical staff bylaws that had not been adopted by the board of trustees and were not binding on the hospital.➤➤

By David W. Townend, JD

Texas courts do not recognize physicians' lawsuits against hospitals for wrongful termination of privileges. But according to *Walls Regional Hospital v Altaras* (2), if a physician can prove that in revoking privileges the hospital denied rights contained in trustee-approved bylaws, he or she may sue for breach of contract. In my opinion, hospital attorneys who write medical staff and hospital bylaws have eroded physicians' rights in favor of the hospital's rights in peer review.

Medical staff members are rarely pro-active in negotiating the terms of bylaws and generally rubber-stamp drafts presented by the administration. There are several possible explanations for this lack of participation in adopting bylaws. Bylaws are usually lengthy and complex, and some physicians never read them. Others may assume the hospital attorneys are looking out for their best interest and don't know there can be a significant conflict of interest as these same attorneys may one day prosecute a peer review action against them.

Another possible explanation is that most physicians may agree that bylaws should be structured to make it easy to revoke privileges of an incompetent physician; however, they may erroneously assume that they will never be the target of such peer review actions.

Whatever the reason, by failing to take a proactive stance in negotiating the terms of hospital and medical staff bylaws, physicians unwittingly have forfeited legal protections in peer review proceedings.

Bylaws traps

Many bylaws give physicians limited rights and tilt the playing field in the administration's favor. Here are a few examples:

- *Prior releases and indemnity clauses.* The Baylor Hospital chain in Dallas, for example, currently requires physicians who are applying for privileges to release and indemnify the hospital and its agents for liability even if the hospital destroys a physician's career. While these prior releases have questionable validity, the hospital's attorneys will seek to enforce them in court even if a physician's privileges have been wrongfully terminated.
- *Abuse of summary suspension.* Historically, summary suspension was reserved for impaired physicians who had become dangerous. But these days, bylaws frequently allow a chief executive officer or a chief of staff to issue a summary suspension even if the physician is not impaired and has no prior history of problems at the institution. Hospital attorneys prefer summary suspension because it allows them to control the review of charts. If hospitals rely on quality assurance review, a physician normally has a right to request an independent review. Summary suspension has the prejudicial effect of labeling a physician as being presumptively guilty before his or her hearing.
- *Exclusive hospital administration rights to appoint the hearing panel.* In addition to writing the rules, the administration normally selects the hearing panel. While many fair-minded physicians have agreed to serve on hearing panels, this presents an opportunity to stack the deck against a physician. There often is no requirement for hearing panel physicians to be of the same specialty as the physician being reviewed. For example, an orthopedic surgeon could sit in judgment on a neurosurgeon.
- *Limited physician rights to discover witness lists and documents.* Although most bylaws permit a physician to have an attorney present and to confront and cross-examine witnesses, many do not allow a physician to receive an advance list of witnesses and documents that may be used against him or her. This can greatly impair physicians' abilities to defend themselves.
- *Frequent lack of standards or guidelines by hearing panels.* To prevail in the civil and criminal justice system, a case must be established using clear standards of proof — either by preponderance of the evidence or beyond a reasonable doubt. But all too often, there are no guidelines or standards for the hearing panel to follow. Can a hospital revoke a physician's privileges based upon a single bad outcome? Or must it prove by substantial evidence based upon a focused review that the physician's practice reflects a pattern of practice that consistently falls below the standard of care?
- *Frequent limiting of the right of access to counsel.* Some hospitals allow a physician to have an attorney, but do not allow the attorney to participate actively in the peer review hearing. This leaves to the physician the task of cross-examining his accusers, despite his lack of training and experience in this art.
- *Bylaws that allow the hospital administration to overturn a hearing panel's decision, even if it favors the physician.* Most bylaws only give physicians procedural protections, which means they give them the right to notice and a hearing. This gives the physician little or no protection to get a fair decision. In any court of civil or criminal law, a litigant has the right to have his or her case tried fairly and the right to a fair judgment if he or she prevails. Most bylaws say that even if a hearing panel rules in favor of a physician, the trustees may overturn that decision at their discretion.

(continued on p 45)

By failing to take a proactive stance in negotiating the terms of hospital and medical staff bylaws, physicians unwittingly have forfeited legal protections in peer review proceedings.

Privileges primer

(continued from p 41)

The hearing

But let's say prevention, for whatever reasons, didn't work. You received an adverse recommendation from a medical executive committee, and you requested a hearing in a timely manner. You should have consulted counsel by now, and not just anybody will do. I recently read an article in a medical journal that advised physicians to contact their local bar associations for referrals. But bar associations, unfortunately, work just like medical societies; you'll get the next 98.6 on the list with a current license. This is one area where you need a true specialist, and you'll want to make the selection the same way you'd select a physician for yourself or a family member: Ask people you respect until one name shows up frequently.

The true specialist will have handled dozens of such matters, will have a firm grasp of clinical issues, and will be a vigorous advocate, but also will have the sensitivity and good sense not to antagonize the hearing panel by wasting time or being unnecessarily contentious. Far too many lawyers try to blame everyone but their clients. Yet, the chances are pretty good that you wouldn't be in a hearing if there weren't some colorable basis for raising questions about your practice, and these questions need to be met head-on, but constructively. This brings us to the issue of your and your lawyer's demeanor. Constructive. Professional. Receptive to constructive criticism. If some real hardball needs to be played, it should be played out between your lawyer and the medical executive committee's lawyer in private. It should never be played out by hounding the chief of staff in 4 hours of cross-examination, a la Perry Mason, in hopes that he or she will break down in tears and own up to the "vast conspiracy" against you.

Remember, it's almost certain that the members of the hearing panel were dragged there kicking and screaming only after they had tried — and failed — to use tricks that had gotten them out of jury duty before.

If your medical staff bylaws are up to standard, the panel members should have no basis for professional or personal bias against you, economic or otherwise, nor should they have participated previously in any investigation of you. Their first inclination should be to regard your situation with the attitude, "There but for the grace of God go I," and they should be looking for some way not to destroy the career of one of their brethren. Cherish and nurture this initial impression because it's your principal asset early in the process. Don't forget, the physician "on trial" has the burden of proof, and it's a tough burden to carry. An arrogant loner, even one who has the facts and the law on his or her side, has a harder time meeting that burden than a physician who offers the hearing panel an opportunity to "rehabilitate" one of its own and to feel good about it.

That is not to say you should go in as a supplicant. If you feel you won't get a fair shake from someone on the panel, your attorney should say so, offer a valid reason why, and make an objection on the record. And again, keep in mind that you aren't before a hearing panel because of some random process. Some of your peers, none of whom — one hopes — enjoyed doing it, concluded that some aspect or aspects of your practice deserved scrutiny. Don't confess to gross malpractice, but if there are some things you perhaps would have looked at differently with the benefit of hindsight, say so. Digging in your heels when even you know you were wrong undercuts your credibility on issues where you weren't wrong.

If there are some things you have done already to improve your clinical skills, tell them about it. Your attorney will doubtless put together lists of colleagues to bear witness for you and hire experts to review your charts and attest to the soundness of your clinical judgment and skill. That's all very well and good. But the doctors on the hearing panel have busy practices and want to hear from you — the sooner in the process, the better. And, unlike a regular jury, they get to ask you questions. Your answers will make or break your case. Be concise. Responsive. Constructive. Professional. Be receptive (like a sponge!) to constructive suggestions for how you can practice better medicine.

The bottom line is that everyone who completed medical school and a residency has a license and current continuing medical education hours, and — unless he or she is a hopeless addict of some kind — is probably competent. But not everyone works and plays well with others. Those who cannot are more likely to find themselves before a review panel.

I offer one last thought: Try to work and play well with the director of nursing. ★

As a lawyer, I'm not qualified to tell you that thorough charting is good medicine, but I am qualified to tell you that it's the best tool you have to defend yourself against criticism.

Mr Larrimer practices health care law with the law firm Cochran & Cochran in Dallas.

Forget fair play

(continued from p 43)

- *Hearsay and an unfair burden of proof.* In some peer review cases, the administration may use the nameless, faceless report of an ad hoc or credentials committee instead of putting a witness on the stand. Some bylaws even say that once such a report is introduced, the burden of proof shifts to the physician. The physician is denied the right to confront and cross-examine his or her accusers, and the burden improperly shifts to the physician to negate the committee's case. This would be analogous to a physician sued in a medical negligence case being presumed negligent upon the reading of the complaint unless he or she proves by substantial evidence that no evidence to support the charge exists. Such an unfair burden of proof is a clear denial of due process rights, but it is used frequently.
- *Omissions or misstatements in an application for privileges.* Some bylaws say any omission or misstatement in an application for privileges, whether material or not, can form the basis to revoke privileges. Hospital authorities can use trivial events to revoke a physician's privileges and impugn his or her integrity. For example, failure to disclose remote and perhaps even forgotten occurrences during residency, such as a lawsuit, a letter of probation, or even a traffic ticket, can become the basis to revoke privileges.
- *Reports sent to the National Practitioner Data Bank.* Hospital administrators, some of whom have little or no experience in writing adverse action reports to the data bank, can cripple a physician's career. For example, an innocent nondisclosure on an application that a physician had been arrested may not only result in revocation of privileges but also a report to the data bank that the physician had lied about this information. I know from experience that once a physician loses privileges at one institution, other institutions and managed care companies will drop him or her routinely from its rolls without an independent review.

Proposed physician Bill of Peer Review Rights

Physicians must read hospital bylaws and be proactive in negotiating their terms. What follows are some, but not necessarily all, of the rights physicians should insist upon.

- Summary suspension should be reserved for physicians who have become dangerous to their patients because of physical or mental impairments. Summary suspension should not be used to revoke the privileges of an unimpaired physician.
- Prior releases and indemnity agreements probably are not enforceable and should be eliminated.
- A physician should have the right to request an independent, focused review before the hearing.
- The hearing panel should be selected jointly by the physician and the administration.
- The administration should bear the burden of proof by substantial evidence to revoke a physician's privileges. The administration should have to prove that the physician's overall practice reflects a pattern that falls below the standard of care. A single event rarely should be the basis of termination. This burden should not be satisfied by introducing an ad hoc or credentials committee report and then requiring the physician to disprove the report.
- A physician who prevails in his peer review case with the hearing panel should have the right to have the board of trustees adopt that judgment. The board should be able to overturn the hearing panel's decision only when the credentials committee or the administration proves through an appeal that the hearing panel's decision was arbitrary, capricious, or unsupported by substantial evidence.
- The physician should have the right to have an attorney present, and his or her attorney should have the right to participate actively in the peer review hearing.
- All physicians should have the right to receive written notice of the charges, all relevant documents (including exculpatory records), and a list of witnesses prior to the hearing.
- If the administration limits use of the summary suspension procedure to truly impaired physicians, then adverse action reports should not have to be sent until after the hearing panel rules. If the hearing panel rules against the physician, he or she should have a right to appeal. Competent counsel should write adverse action reports, and drafts should be shown to the physician for clarification before being sent to the National Practitioner Data Bank.
- A physician's privileges should not be terminated for not disclosing certain information in an application unless that information is material, which means that if it had been disclosed, the physician's application for privileges would be denied.

Physicians must level the playing field and insist upon more protection in peer review proceedings. Bylaws should be structured in such a way that if a physician's rights are denied, then he or she has the right to bring a legal action. This certainly would give physicians more justice in peer review proceedings. ★

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Mr Townend is an attorney with the law firm Brown, Brown, Chandler & Townend in Garland.

Best of both worlds

Houston physician puts patients first and runs an efficient practice

Karen Cottingham, MD, visits with patient Sandra Lohse.

Photo by Theresa DiMenno

The business side of her practice was out of control. Karen Cottingham, MD, was a member of a large group practice, and she paid a heavy emotional and financial price for not understanding the administrative intricacies of getting paid. That was several years ago. Today, the Houston oncologist and internist not only runs a model practice by using smart tactics for getting paid *exactly* what she's owed, but she also is considered a pioneer for her patient advocacy efforts.

By Laurie Stoneham, Associate editor

When Pat Coffey first met Dr Cottingham nearly 2 years ago during one of the mini-consults he conducts throughout the state, he says she was overwhelmed with the complexity of dealing with the carriers. Mr Coffey, director of payment advocacy for the Texas Medical Association, recalls that Dr Cottingham had "large outstanding receivables and no coherent procedures in place for addressing these payment issues. She always had the caring attitude and advocacy for her patients. What she lacked was the hands-on business insights. Now she has the best of both worlds."

Her leap into solo practice 18 months ago came at the encouragement of patients, many of whom are cancer survivors of many years and who now are under her care as an internist. Dr Cottingham, along with her office manager, Albert Ramos, CPA, began building a new way of caring for patients.

Their success lies in their attention to detail. Nothing escapes their scrutiny. From the colors and antiques used throughout the office to the vase patients keep filled with bright, cheerful flowers, there's something extraordinary about the passion Dr Cottingham brings to every aspect of patient care. But when it comes to managing the business side of her practice, she's a soft-spoken warrior. Her diligence and tenacity have paid off.

Overcoming slow pay, low pay, no pay

Dr Cottingham refuses to monkey around with insurers who don't pay her correctly or who try to intimidate her by suggesting that she has been overpaid. And according to Mr Ramos, "90% of managed care explanations of benefits (EOBs) are wrong." They overcome the endless array of hassles and problems with a system of forms, policies, and procedures that helps them track every detail of patient care and validate the accuracy of every bill that comes in.

"If we're merely serving ourselves, then it would be extremely cynical. But as it is, we know we're providing a very high level of service in an office like this," said Mr Ramos. "Dr Cottingham sees each of her patients. She spends time with them, she holds their hands, and she walks with them down the hallway hand-in-hand if that's what they need. She listens to them, and she understands their needs."

Dr Cottingham stresses, "We try to deal with the insurance companies and handle the problems so the patients don't have to get in the middle."

The system they have created is designed to improve efficiency and effectiveness for patient care and to reduce the administrative burdens. Here are the elements of their system:

- The practice maintains a 3-ring binder containing the contract fee schedules of her patients' insurance plans. Each plan has an individual sheet listing the top 100 CPT codes used in the practice. The information is on white paper and is listed 1 code per line. CPT codes are arranged in the same order for each plan. Dr Cottingham's management group assembled the book. Mr Ramos suggests asking for the data as a simple list, not in a spreadsheet, making sure that you have the same information for each plan. For individual contracts, get the fee schedule in the format needed directly from the insurance company.
- Along with helping to verify payment accuracy, the data also help Dr Cottingham and Mr Ramos compare the performance of the insurance plans. "One plan may pay you 50% of what you would charge normally, and it's more profitable than the plan that pays you 80%, if the 80% plan makes you jump through 25 hoops just to say 'good morning' to a patient," Mr Ramos said.
- EOBs are examined line by line. Mr Ramos says some EOBs are impossible to analyze for accuracy because of missing information. CPT codes may not appear, or there may be only 1 line itemization per patient, or there may just be what he calls a "bulk remittance" where only a lump-sum payment is noted. In these cases, he calls the insurance company and begins the battle of getting paid as promised.
- A problem resolution sheet is maintained to record all pertinent information about attempts to communicate with insurance companies. It includes the date of the call; the name and telephone and fax numbers of the company representative; what was discussed; and the action taken. Mr Ramos says most representatives won't give their individual extensions; he cajoles them or keeps asking every few minutes until he gets the number.
- Once a problem becomes apparent, such as a code being paid incorrectly, Mr Ramos stops all billing to that insurer until the mistake is corrected.
- Mr Ramos doesn't let insurance clerks plead ignorance. He faxes a copy of the fee schedule or the CPT code, whatever backup documentation is needed to resolve the matter. He follows up the conversation with a letter (a form already created) that explains the discrepancy and requests correct payment, and sends copies to the Texas Department of Insurance and TMA. Correct payment usually is forthcoming, but he admits it takes a while, sometimes months.
- Alleged overpayments are scrutinized. Dr Cottingham recalls one carrier demanding repayment of $200. "We were getting threatening letters, and it was all very intimidating." After numerous attempts to resolve the situation, she finally spent an entire afternoon on the phone. "Everyone told me something a little bit different. I finally said I would be happy to pay whatever I owed but that I wanted to see a detailed itemization." The matter was dropped when the in-

"She always had the caring attitude and advocacy for her patients. What she lacked was the hands-on business insights. Now she has the best of both worlds."

surer couldn't document the alleged overpayment. She says it was worth her time. "I feel like I can hold my own in these conversations now and that it's reasonable for me to ask if they have the correct fee schedules in their computers. I would never have dreamed of asking that question a year ago, but now I know that's an obvious question to ask." Mr Ramos says it is important to have insurance plans prove their claims.

- Forms have been developed for everything from prescriptions to ordering outside tests to streamlining transactions with outside vendors. The initial insurance verification form describes the type of plan and defines the network affiliation. "So if we are paid an amount and are told it's because it's a such-and-such network discount, we can go back and see if in fact that's applicable," Mr Ramos said.

Championing patients

This same attention to detail flows over into her patient care. The decor of her office says a great deal about her thoroughness. "We spent a lot of time thinking about the colors and textures and furniture positions and accents. We're trying to convey the idea to folks that when they walk in, this is their sanctuary," Dr Cottingham said. "We went through quite a decision process about the color of paint for the walls in the reception area, and even the final coat wasn't just right. It seemed a little drab and a little bit depressing. Then we found this other paint that is much warmer and uplifting, so we went to the trouble of repainting the entire room."

There are no sliding glass doors at the reception area. Patients sign in on an open granite counter. Dr Cottingham thinks this symbolizes openness and availability and improves communication by helping patients feel included. She says patients have responded very favorably.

Bette Conerly has been seeing Dr Cottingham since last summer. "There are no hard edges in the office. I mean that literally and physically. There are no hard metal shelves and cases. Everything is soft. There also are no hard edges on the people who work there," she said.

"We want people to have something pretty to look at, to have diversions, and to have other nice people to talk to," Dr Cottingham explains. "I want them to feel comfortable and confident, and the best thing I can do is try to provide an atmosphere that relieves anxiety and stress and promotes healing."

"I want them to feel comfortable and confident, and the best thing I can do is try to provide an atmosphere that relieves anxiety and stress and promotes healing."

"A little extra attention can sometimes change the entire atmosphere of any organization because there is so much stress in health care today."

Original artwork brightens the offices.

Patients receive chemotherapy in comfortable, home-like settings.

This piece of furniture had once been in Dr Cottingham's home.

Emotional healing

The room where patients receive chemotherapy is affectionately known as "the party room," according to patient Barbara Janusz, who says she and her friends "hoop and holler in there." Support groups have formed for patients to ask each other questions and know what to expect. "Believe it or not, you can have fun and chemotherapy at the same time in that office," Ms Conerly said.

The flower arrangement on the reception counter is known as "the perpetual bouquet." Patients bring in plants and flowers to add to the arrangement almost daily. "It's very important that you have something that's alive and beautiful," says Ms Janusz.

Patients are welcomed in a reception area decorated with rich textures, colors, and antiques.

The examination rooms are furnished with antiques.

Another patient, Sandra Lohse, has high praise for Dr Cottingham's efforts. When ovarian cancer reappeared, she was under the care of another physician. She went to see Dr Cottingham at a friend's suggestion. The cancer was advanced and aggressive. "I really thought I was going to die. I didn't feel I could bear the treatment," she said.

Ms Lohse says Dr Cottingham "will sit down with me, take my hand, and say, 'You're feeling worse because you need to be good to yourself.' So my whole emotional reaction to the treatment is different because of Dr Cottingham. She makes you want to get well. She gives you confidence in the drugs and in yourself. She gives you the will to live."

Respecting patients first

It's all about respect and caring for the patient, Dr Cottingham believes. "This determines how we treat our patients, their records, their phone calls, and their insurance needs. We want everything to be accurate and precise."

Two experts say Dr Cottingham is on the right track.

David Woods, editor of *Medical Practice Communicator,* a monthly newsletter that discusses the power of effective patient communication, says these things make a difference. "Somebody who pays so much attention to detail and to the well-being of her patients but also applies the same kind of thoroughness to the business side of medicine is probably a pretty exemplary physician. She may be a pioneer in that regard and may have something to teach other physicians."

Susan Keane Baker, consultant and author of *Managing Patient Expectations,* adds, "A little extra thoughtfulness, a little extra attention can sometimes change the entire atmosphere of any organization because there is so much stress in health care today." ★

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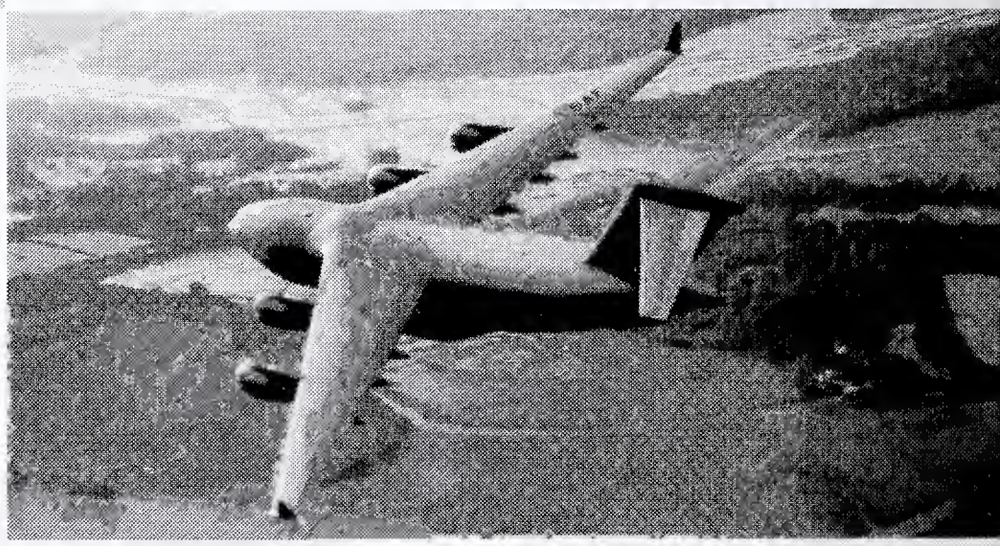

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Producing physicians for South Texas

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South Texas, one of the fastest growing regions in the country, remains among the most medically underserved, in part, because few students from South Texas enter medical school. To address this issue and to increase the diversity of the matriculant pool, Baylor College of Medicine (BCM) and The University of Texas-Pan American (UT-PA) established in 1994 the Premedical Honors College (PHC), a rigorous undergraduate program at UT-PA for students from South Texas high schools. Students who complete all PHC requirements and BCM prerequisites are accepted into BCM upon graduation from UT-PA. Those in good standing receive counseling, enrichment experiences, and tuition and fee waivers from UT-PA and BCM. The program is increasing the number of students from South Texas universities matriculating into medical school, and is expanding the involvement of local physicians in undergraduate education, heightening visibility for partner institutions, and becoming an effective, replicable bachelor of science/doctor of medicine model.

Dr Thomson, director, Center for Educational Outreach; Mr Denk, senior editor and administrative associate; Ms Ferry, education coordinator; and Dr Michael, assistant dean, Office of Admissions, Baylor College of Medicine; and Dr Martinez-Wedig, program coordinator, Biology Department, The University of Texas-Pan American. Send reprint requests to Dr Thomson, director, Center for Educational Outreach, Baylor College of Medicine, 1709 Dryden, Ste 545, Houston, TX 77030.

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INTRODUCTION

Lack of health care in South Texas

South Texas, defined roughly here as the area from Corpus Christi to Laredo and all points south, is one of the fastest growing regions of Texas and the United States. It encompasses the southernmost counties of Texas: Brooks, Cameron, Duval, Hidalgo, Jim Hogg, Jim Wells, Kenedy, Kleberg, Nueces, Starr, Webb, Willacy, and Zapata. Its July 1996 population of 1.5 million represents a growth of 49% from April 1990. (During the same time period, the state's overall population increased by 12% and the US population increased by 6%.) About 70% of this region's population is Hispanic (1).

Rapid growth has provided new opportunities but has not eliminated many of the region's most pressing problems. In fact, South Texas remains among the most medically underserved and poorest areas in the United States. As of 1996, 37.7% of the families in this region were impoverished, as defined by the federal poverty index (compared with 19.0% statewide and 13.7% nationally); 12.8% of the work force was unemployed, the highest rate of unemployment in any region of Texas (the statewide and national unemployment rates were 5.6% and 5.4%, respectively); 7.8% of families in the region were on Aid to Families with Dependent Children (compared with 3.7% statewide); and 31.2% received food stamps (compared with 13.1% statewide) (2).

As of May 1997, the number of physicians practicing in Texas was 47,448 (75.1% white, 11.0% Asian, 8.4% Hispanic, 2.9% African American, and 2.6% other), with most clustered in urban areas. In fact, while 80% of Texas is designated as "rural," only 12% of the primary care physicians in Texas practice in rural areas. Thus, many rural regions, like South Texas, are suffering from serious shortages of health care (3), and it is not surprising that all 13 South Texas counties are identified by the US government as medically underserved and that 11 also are designated as health professional shortage areas (4). Four of the 13 counties have only 2 or 3 physicians, and 1 of these counties has no physicians at all (3).

Part of the difficulty in recruiting physicians to South Texas is that this region has not had great success in producing medical students. Therefore, not many physicians grew up in South Texas and understand its social and cultural mores. The 5 undergraduate schools in the region have an annual cumulative enrollment of about 30,000 students (80% Mexican American). However, in 1995, only 14 students from these schools applied to US medical schools and only 8 matriculated. In 1996, only 23 students from these undergraduate institutions applied to medical school and only 4 matriculated; the following year, 26 students from these schools applied to medical school, and 9 were accepted (R. Haynes, oral communications, October 1997 and January 1998).

Baylor College of Medicine's history in South Texas

In 1983, Baylor College of Medicine (BCM) took the first of many steps to address these issues. The medical college teamed with the South Texas Independent School District to create the South Texas High School for Health Professions in Mercedes (modeled after Houston's own DeBakey High School for Health Professions). Since then, BCM has enjoyed a strong relationship with the South Texas community and has become a partner in 4 additional magnet high school programs in the region (in Laredo, Corpus Christi, Edinburg, and Mercedes). These programs are designed specifically to enhance the science, mathematics, health, and

technology education available to students in South Texas. Many of their graduates have accessed medical education and become physicians and health care professionals.

BCM's success in working with public high schools led to discussions with The University of Texas-Pan American (UT-PA), the largest university in South Texas, with almost 14,000 students. In 1993, the president at UT-PA and senior level administrators at BCM visualized a new bachelor of science/doctor of medicine (BS/MD) program that would be open to South Texas students and capitalize on BCM's network of magnet schools already established in the region.

Immediate advantages for UT-PA would be access to a larger pool of academically strong South Texas students and the potential to increase the number of UT-PA graduates accessing medical education. The university also viewed this partnership with BCM as an opportunity to strengthen its community relationships through student preceptorships with local physicians, some of whom are BCM alumni. BCM viewed the partnership as a means to increase the number of students from South Texas who attend BCM, become physicians, and return to the medically underserved region of South Texas to practice.

With partial funding from the US Department of Health and Human Resources, Bureau of Health Professions, Division of Disadvantaged Assistance, BCM and UT-PA opened the undergraduate component of their joint BS/MD program — the Premedical Honors College (PHC) — in 1994. The first group of South Texas high school graduates was welcomed that fall. As of October 1998, the program has 72 students in 4 undergraduate classes. A new class of 20 to 25 students will enter next fall. BCM welcomed its first cohort of PHC graduates in summer 1998. Four of these original 8 graduates matriculated into BCM; the remaining 4 matriculated into other medical schools. Reflecting the South Texas population, approximately 90% of PHC students are Hispanic/Mexican American.

Table 1. Premedical Honors College applicant/acceptance profiles.

	1994	1995	1996	1997	1998
Initial applications	76	94	129	165	128
Average SAT	920	960	1049	1040	1102
Average HS GPA	N/A	N/A	89.7	90.5	91.1
Students interviewed	28	40	42	43	35
Students accepted	18	28	28	28	26
Students matriculated	16	23	24	21	15
Students currently enrolled	8*	15	23	20	15

* Eight students graduated from the Premedical Honors College in May 1998. Of these, 4 are enrolled at Baylor College of Medicine and 4 at other Texas medical schools.
SAT = Scholastic Aptitude Test
HS GPA = high school grade point average

METHODS

The Premedical Honors College

PHC is housed at UT-PA in Edinburg. It provides rigorous and varied undergraduate educational experiences designed to ensure that students receive the academic and emotional preparation required to succeed in medical school. Students are selected for the PHC as high school seniors. They attend UT-PA for all 4 years of their undergraduate education and receive conditional acceptance to BCM upon acceptance into the PHC. Those who complete all PHC requirements and BCM prerequisites are accepted into BCM upon graduation from UT-PA. This is a significant program benefit, especially when we consider that 43,020 students applied to US medical schools in 1997, but only 16,165 (38%) were admitted (5).

Faculty from BCM and UT-PA have worked together to create a 4-year undergraduate curriculum that presents concepts in an integrated manner and revisits concepts over the course of 4 years. The curriculum focuses on science, math, communications, and technology, and all PHC students are required to major in biology or chemistry. Students who major in biology must minor in chemistry, and vice versa.

Each year, up to 25 students are recruited into the PHC from the South Texas High School for Health Professions, the Science Academy of South Texas, and other high schools in South Texas. Project staff travel to high schools throughout the region giving presentations on the PHC and speaking individually with students, parents, and school counselors. In addition, informational letters and program brochures are sent to the homes of students in the region. As indicated in Table 1, the number and qualifications of applicants have increased annually.

Program selection is based upon students' previous academic performances, achievement on the Scholastic Aptitude Test (SAT) (which they must take to be considered for the program), letters of recommendation, and other indicators. Attendance, citizenship/deportment, and participation in extramural activities also are considered in making final selections. Specifically, students must have completed and passed at least 4 years (credits) each of high school science and mathematics, including chemistry and elementary analysis/precalculus. They also are required to have taken and passed at least 1 year of computer technology (a Texas state requirement).

Table 2. Premedical Honors College interview profile.

	1994	1995	1996	1997	1998
Students interviewed	28	40	42	43	35
High schools represented	10	24	21	23	20
Average SAT	1026	1056	1177	1212	1233
Average HS GPA	92.0	94.9	93.9	94.0	94.6
Average HS science GPA	88.8	91.3	92.0	93.7	93.6
Average HS class rank	Top 16%	Top 5%	Top 7%	Top 4%	Top 4%

SAT = Scholastic Aptitude Test
HS GPA = high school grade point average

Table 3. Premedical Honors College matriculant profiles.

	1994	1995	1996	1997	1998
Students matriculated	16	23	24	21	15
High schools represented	7	17	13	14	11
Average SAT	1051	1076	1185	1212	1214
Average HS GPA	92.0	95.0	93.2	93.8	95.4
Average HS science GPA	89.7	91.4	91.6	93.8	94.6
Average HS class rank	Top 10%	Top 6%	Top 10%	Top 4%	Top 5%

SAT = Scholastic Aptitude Test
HS GPA = high school grade point average

All "finalists" for PHC acceptance (usually about 40 applicants per year) are flown free, compliments of Continental Airlines, to Houston for interviews with BCM's Medical School Admissions Committee. This committee interviews and evaluates the students, following the same format used for medical school applicants. Students' maturity, life experiences, motivation, interpersonal/communication skills, and academic/research background are important components of the evaluation. Following the interviews, up to 25 students are selected for the program, and another 2 to 3 alternates are identified (Table 2).

As noted in Table 3, students who finally matriculate into the PHC tend to be in the top 10% of their graduating high school classes and to have high school grade point averages of about 94. Their SAT scores in 1995 and 1996 (1185 and 1212, respectively) are considerably higher than average SAT scores for Texas (996 and 995, respectively) and the United States (1010 and 1013) (6).

To remain in the program, students must maintain an overall undergraduate grade point average of at least 3.2 and a science grade point average of at least 3.0. Students whose overall grade point averages fall below 3.2 during any semester at UT-PA receive "warning" letters at the end of that semester. Students who receive 4 warning letters are dismissed from the program.

To matriculate into BCM, all PHC students must take the Medical College Aptitude Test (MCAT). The minimum MCAT score required for PHC students to matriculate into BCM has risen from 23 for students accepted into the PHC in 1994 to 25 for students accepted into the PHC in 1998. (The national MCAT average for Mexican American students matriculating into medical school in 1996 was 24.5.) (7).

Since 1994 when the program opened, 18 PHC students have either left or been dismissed from the program. Six of these students have withdrawn because of family problems, dropping out of school, and/or changing undergraduate majors. The remaining 12 students were dismissed from the program after 4 semesters of insufficient academic progress. Students who have not fared well generally had a difficult time adjusting to college life and may not have had time management and study skills comparable to more successful students. In addition, the first-year mathematics courses (calculus and precalculus) have proved challenging for most students. Both UT-PA and BCM continue to advise students who leave the program regarding access to health careers. The first group of PHC students graduated in May 1998.

PHC program characteristics

The PHC includes some components of successful BS/MD programs elsewhere. Specifically, it was designed to include the following characteristics.

- *High degree of program structure providing students with very clear directions about what is expected of them on a day-to-day basis and over the program duration.* The PHC promotes focused learning, with required tutoring and support services at each academic level, reinforced through structured enrichment activities. The schedule and curriculum are such that students receive a clear understanding of their program-related responsibilities and have little opportunity to be distracted. Clearly informed of the program's rigor, expectations, and benefits, and provided with the support and assistance needed to succeed, students are motivated and able to perform at their highest levels.
- *Frequent contact and well-established, readily accessible systems of*

support and assistance to deal with intervening factors. Both UT-PA and BCM have mechanisms in place for counseling and support to assist students with academic, personal, and financial problems that can impede progress. The PHC program coordinator, a faculty member in the Department of Biology at UT-PA, interfaces often with other UT-PA faculty and staff involved with PHC students to identify potential problems. The coordinator works to assure the availability of qualified professionals (including herself) who can help students complete required course work and resolve problems that may arise during the program. These individuals are knowledgeable about cultural considerations that may influence students' behaviors, and they provide guidance to help students attain educational goals. In addition, older PHC students serve as tutors and counselors for younger students.

During their junior and senior years, PHC students participate in MCAT preparation, provided as part of the program. Through a contract with a professional examination review group, students attend weekly sessions from January through April (for the April administration of the MCAT) and from June through August (for the August administration).

In addition, during its first 2 years in the PHC, each entering group of students is enrolled as a cohort. These students take classes together, form study groups together, and socialize together. They form friendships with their PHC colleagues, who have similar goals and interests. Informal interviews with PHC students suggest that their peer groups are both motivating and reassuring and that program students form their strongest bonds with other students in the PHC.

- *Exposure to medicine — through enrichment programs, field trips, classroom activities, and mentorships with physicians in South Texas — to help students understand professional options, the commitment required, and the rewards associated with medical careers.* Throughout the undergraduate program, students are engaged in learning activities that focus on health issues, particularly those in South Texas. Regular and varied exposure to professional medical environments through student mentorships and site-based learning opportunities in local hospitals and clinics is an important aspect of the PHC.

To begin students' socialization into medicine, BCM faculty members and medical students meet periodically in Edinburg with PHC students to discuss clinical and research activities. These sessions provide a forum for PHC students to learn about careers in medicine and the medical school experience. To promote greater communication, PHC students are provided e-mail accounts so they may interact with BCM faculty, staff, and students as well as with preceptors and research scientists with whom they have worked.

In addition, all PHC students are required to attend a 6-week academic and enrichment program in Houston during the summer after their freshman year. The program, a partnership between BCM and Rice University, includes rigorous course work in science and English as well as clinical and laboratory experiences. Daily preceptorships with BCM faculty offer a firsthand glimpse of the day-to-day practice of medicine, including its rewards and challenges. Students also are exposed to the medical school environment through gross anatomy lab experiences. The program emphasizes development of the communication skills necessary for doctor-patient relations and for interaction with other medical professionals.

In subsequent summers and during the academic year, students participate in preceptorships and research experiences in South Texas and elsewhere. During summer 1996, a total of 14 PHC students participated in clinical activities with South Texas physicians; 12 students attended South Texas preceptorships during summer 1997, and 16 during 1998. Also, PHC students (6 in 1996, 12 in 1997, and 18 in 1998) have participated in summer research programs at Louisiana State University, BCM, UT-PA, and other sites. Several students have been engaged actively in research projects at UT-PA throughout the academic year. One student attended a summer enrichment program in 1997 at The University of Texas Medical Branch (UTMB) at Galveston. Eight students attended summer enrichment programs in 1998 at UTMB or UT-PA, 1 student participated in the DeBakey Summer Surgery Program at BCM, and 2 pursued research or studies in Latin America.

South Texas preceptorship experiences are arranged for students during their sophomore and junior years. Note that 594 physicians (257 of whom are Hispanic) are located within close proximity of UT-PA. Further, more than 60 BCM alumni practice in South Texas. Working in area clinics and hospitals exposes students to the health problems and cultural and health care issues affecting the local population. Such experiences are especially important in helping students to develop relationships with local practitioners, who become mentors. Preceptors remain in contact with students throughout their undergraduate years, encourage students

to stay focused on their career objectives, and often provide summer and part-time employment and letters of recommendation. The physician mentors have been extremely supportive of the program and have even begun a scholarship fund for PHC students.

- *Direct student financial aid.* Many talented and ambitious PHC students would be unable to pursue undergraduate premedical studies and careers in medicine without financial assistance. Students selected for the PHC program receive full tuition and fee waivers, along with other financial assistance, during their 4 years of undergraduate study at UT-PA. Upon students' completion of the undergraduate PHC program and admission into BCM, all medical school tuition and fees are covered by BCM. When possible, other incidental costs (eg, books, air fare to Houston, and backpacks) are covered, and UT-PA and BCM staff work with students to help them secure sufficient financial aid to assure their completion of all program components. Costs associated with financial aid and counseling are borne by UT-PA and BCM as an in-kind contribution to the project.

RESULTS

Available data suggest that the program is having a positive impact. First and foremost, assuming that most of the students currently enrolled in the PHC continue to achieve satisfactory academic progress and matriculate into BCM or some other medical school, the PHC will have produced a significant increase in the pool of medical school students from South Texas. Given that only 4 students from South Texas universities matriculated into US medical schools in 1996, this outcome would be meaningful indeed.

The initial group of PHC students graduated from UT-PA in May 1998. All 8 graduates matriculated into medical school in the fall of 1998, 4 at BCM and 4 at other Texas medical schools. This total is double the number of medical school matriculants from South Texas universities in 1996. In future years, this number will continue to grow with the size of the respective PHC classes (Table 3). Moreover, aside from the 8 PHC students who entered medical school in 1998, an additional 6 UT-PA students were accepted. Thus, a total of 14 UT-PA students matriculated into medical school in the fall of 1998 — a 55% increase over the previous combined high total (n=9) for *all* 5 South Texas undergraduate schools since 1995.

Furthermore, over the past 5 years, the PHC appears to have influenced the culture at UT-PA by impacting not only students in the program but also the health-related interests of all entering students at the university. For instance, since the PHC was established, the number of freshman biology majors at UT-PA declaring themselves as premedical students has increased from 48 (fall 1993) to 111 (fall 1997). The total number of biology premedical majors at UT-PA (freshman through senior) has increased from 198 in fall 1993 to 366 in fall 1997.

The PHC also may be encouraging some of the area's stronger students to remain in South Texas and attend UT-PA. We hope that this trend will continue and that a more proportionate number of students from South Texas will begin to matriculate into medical school.

DISCUSSION

The PHC is an experimental program that will be evaluated for many years. Only time will demonstrate its long-term success, based on the number of PHC students who become physicians and return to practice in South Texas. However, initial indices are highly encouraging. In the fall of 1998, the PHC began to show a major impact on the region's medical school matriculation rate, as PHC graduates doubled the number of students from all 5 South Texas universities who matriculated into medical school in 1996.

The PHC has established a viable high school-through-medical school model that can be replicated at other sites. This program has shown that students who are enthusiastic and above average academically can thrive in a highly structured and supportive environment that requires them to remain focused on their medicine-related career goals. In addition, the PHC has benefited and enhanced the visibility of both partner institutions, and has demonstrated that talented students will attend local universities when provided with attractive options.

The PHC also has spurred many South Texas physicians to become involved in undergraduate education. A network of area physicians is now in place; they provide support, guidance, encouragement, and practical experiences to PHC students, and have taken a real interest in the program. These physicians refer to PHC students as "our students" and have taken a sense of ownership in the program. In this way, the PHC has served to tie area health care providers to UT-PA, to BCM, and most importantly, to PHC students. In these many ways, we hope that the Premedical Honors College is helping to prepare South Texas' next generation of medical leaders and health care providers.

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Shifting the costs of indigent care back to county governments

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Despite a decade of steadily rising prosperity, Texans are losing health care benefits at an alarming rate. As many as 41 million people in this country, or 15% of the population, lack health care coverage of any kind. Most of these people are under age 65 and are gainfully employed, but their employers don't provide coverage and/or don't pay them enough to afford it themselves. Most have minimum wage jobs and are ineligible for Medicaid. These individuals plant the gardens, work in fine restaurants, clean expensive houses, and generally benefit the communities in which they reside.

Texas law suggests that county governments and property owners should pick up the tab for the medically indigent. However, as the uninsured numbers grow, county governments are finding ways to extricate their taxpayers and the institutions they support from the obligatory role as payer of "last resort" for these people.

While reimbursement from government programs, managed care, and commercial insurers is putting tremendous financial pressure on health care providers, the county systems simply are not assuming their financial, legal, or ethical responsibilities for those outside the protective cover of these programs. In my experience, health care for the medically indigent has become "charity care" at the profit and nonprofit hospitals in the state. The strain is palpable in the emergency rooms, where by law the medical crises of the poor must be treated. This defacto safety net is fraying, and our political leaders need to make the painful decision to raise sufficient tax revenues to remove the weight.

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The financial responsibility of providing health care for indigents has rested traditionally on local governments. Despite this premise, many physicians are obligated professionally to render care to many patients irrespective of financial reward or county support. In an emergency room practice such as mine, every person who walks through the door must be evaluated and screened. Those suffering a medical emergency require treatment to comply with state and federal statutes mandating care for emergency services (1,2). The issue of reimbursement for the care we provide to those patients who cannot pay their bills is rarely resolved at the time services are rendered, whether emergent or not. Furthermore, federal and state laws also obligate inpatient care by attending physicians and prohibit transfer of these patients until they are stable (2,3).

Complicating these legislative mandates is a disturbing trend by other segments of our society to further shift these costs back to the health care providers, including the county governments of this state. Cost-driven policies by employers have brought us a "medically indigent" working class. Third-party payers are reducing reimbursement for their insured subscribers. Government programs to "reform" and reduce welfare payments are reducing Medicaid monies. Accordingly, for many Texas indigents and Texas physicians practicing in Texas, the buck now stops at the door of their local hospital emergency rooms. Since the evolution of English Common Law, paupers have been the "wards of the state," and the law in Texas is that the county government is responsible for indigent care. Despite constitutional and statutory mandates, some county governments shirk their obligations to provide health care for indigents.

COUNTY CONSTITUTIONAL DUTY

Counties that opt to create public hospital districts are legally liable for medical services provided to their indigent residents. According to the Texas Constitution (4), Texas counties are empowered to create legal entities or hospital districts with the authority to tax the property owners so that they can provide health care to their indigent inhabitants. Article IX, which provides for the creation of hospital districts by Texas counties, states in plain terms, "that any district so created shall assume full responsibility for providing the medical and hospital care for its needy inhabitants. . . ." Counties and their governing bodies (the county commissioners) are empowered to levy an ad valorem tax up to 75 cents on every $100 valuation on all property within their boundaries to fund this care.

Despite these provisions, some Texas counties that have created a hospital district are reluctant to levy sufficient taxes to adequately fund their hospitals. Although this taxing authority is discretionary and can be adjusted up or down by 3% per year, some county governments prefer to limit taxes rather than propose a tax increase to fund indigent care for fear of the local political backlash. Limiting taxes on property owners and shifting costs to the private health care sector would appear to be more politically correct. In rural counties, however, where county commissioners do not have the private sector to fall back on, discretionary powers to raise sufficient taxes to cover costs are more likely to be used regardless of political fallout.

The result in many urban counties is that these costs are shifted onto the shoulders of the health care providers in the private sector through emergency room visits, consults, and admissions. Instead of taxing business and property owners, county governments

are passing the costs of indigent care on to the private sector. Furthermore, preventive health care is delayed, and these delays ultimately result in crisis management, thereby displacing preventive care with emergency care.

In Bexar County, for example, the Bexar County commissioners voted recently to close the only county-funded 24-hour downtown acute care facility. Effective April 1, 1997, the Brady-Green Clinic (formerly the Robert B. Green Hospital) is now closed to all walk-in patients who do not have appointments and/or who present after hours. As a result, all the inner-city episodic care is left to the 2 downtown hospitals (Baptist and Santa Rosa), which are not county funded. Despite the thousands of indigent inner-city residents who live in the "central barrio" and work in and around the burgeoning River Walk businesses, access to the county health care system on an episodic basis is restricted to those who make the effort to travel to University Hospital on "the Hill" in northwest Bexar County. Underlying these cost-cutting decisions by the Bexar County commissioners is the fact that they levy only 24.8 cents on each $100 of property value — one third of the level permitted. Rather than impose the necessary taxes on the landowners and provide an inner-city facility, the commissioners deemed it more efficient and politically correct to close facilities and shift costs to private health care providers. This problem is troublesome for many physicians and hospitals that face the closure of essential public facilities with a bitter realization that their responsibility to care for indigent patients will grow accordingly.

According to Article IX of the Texas Constitution, once a county creates a hospital district, it is barred from dissolving its hospital district without acquiring the authorization to do so from a majority of qualified voters within the district. The Bexar County commissioners avoided such a referendum because University (Bexar County) Hospital no longer resides in the inner city and is conveniently out of reach to those without private transportation. The interests of the medical community and the patients are clearly not being represented by the Bexar County commissioners. They moved the hospital and shifted the costs to the private sector.

For example, as I prepared for a recent night shift at one of the downtown hospitals, I was jogging with an acquaintance who owns a trendy restaurant on the River Walk. He was applauding my efforts in treating "those people" of the inner city, affirming the fact that somebody has to do it. Later that night, one of his kitchen workers presented with appendicitis. The patient was a recent immigrant from south of the border who did not qualify for Medicaid and who, as you might expect, had no benefits from my friend's restaurant. The general surgeon was called, and the patient was admitted for an appendectomy. My collection rate for private payers is 8%, less than the gratuity I leave the wait staff at my friend's restaurant. Is this equitable?

By comparison, in rural Haskell County during the same year, county commissioners levied 34 cents per $100 on property to support the hospital district because residents have no other facilities within 70 miles to fall back on. That translates to a 30% differential in the mill levy rate between Haskell and Bexar counties. If the same rate were applied to Bexar County property owners, the hospital district would raise an additional $27 million in property tax revenue to meet its obligations to provide indigent health care. The reason for the difference in my opinion is clear: Haskell County has only 1 facility with no sizable private sector onto which to shift its costs.

COUNTY STATUTORY DUTY: COUNTY INDIGENT HEALTH CARE PROGRAM

The Indigent Health Care and Treatment Act

The constitutional duty imposed on certain counties that opt to provide health care through the creation of a hospital district has been supplemented and, in effect, extended to all Texas counties by the Indigent Health Care and Treatment Act (5). In effect, this state law requires each and every county to provide preventive and emergency care to county residents who are indigent and not otherwise covered by another source. This means that health care providers are entitled to reimbursement from the county for services rendered to "eligible residents." The Indigent Health Care and Treatment Act created the County Indigent Health Care Program (CIHCP) to fill the void where other federal and state programs do not provide medical coverage to indigents. The Texas Department of Health (TDH) has established the minimal eligibility restrictions. Most Texas physicians should seek reimbursement for the indigent care they provide directly from the county government by completing and submitting a Form 100, available from TDH at (512) 338-6461. The county government, not TDH, is responsible for generating the tax revenues and making the disbursements to health care providers up to a ceiling of 10% of its general tax revenue. Beyond that, the state CIHCP has an assistance program for counties once they expend more than 10% of their tax revenue. Whether or not a physician receives his payment will in most cases depend on physician compliance with the procedures and patient eligibility, which will be determined on a case-by-case basis by the county.

Covered services

The Indigent Health Care and Treatment Act sets forth the basic services to indi-

gent patients that each county is obliged to provide to comply with the law. Although such terms as "medically necessary" are present and are always subject to dispute, the Texas Indigent Health Care and Treatment Act authorizes the Texas Department of Human Services to delineate specifically the minimal care that counties must provide. According to Section 61.028 of the act, a county shall provide for medically necessary inpatient and outpatient services, emergency care, laboratory and radiographic services in support of the above, family planning services, payment for not more than 3 prescription drugs per month, and skilled nursing facility services, regardless of the patient's age. The act states further that counties may offer additional health services, but such additional care will not be reimbursed by the state. A county's liability is limited to $30,000 or payment of 30 days of hospitalization up to 10% of its tax revenue. No enforcement authority is provided for in the act.

Eligibility criteria: defining the indigent

In determining patient eligibility (Section 61.023), each county must follow the general scheme of the act but can apply criteria less stringent than those of TDH in determining eligibility. Counties must make a reasonable effort to notify the public of their standards no later than the beginning of each state fiscal year. Therefore, because criteria may vary from county to county, providers should contact the county in which they practice to be certain of its eligibility requirements. Most counties will follow the Indigent Health Care and Treatment Act's list of requirements to some degree.

First among the eligibility criteria is county residency. According to the criteria established by the CIHCP, a patient need not have obtained US citizenship or legal entry to receive subsidized medical care from the county. Instead, patients need to establish that they intend to reside in the county in which they have received the medical care or that they do not otherwise reside in the service area of a different public hospital or hospital district. Although the CIHCP manual couches this language in terms of providing assistance only to residents of the county in which the patients apply for assistance, former Texas Atty Gen Dan Morales has interpreted the provisions of the residency requirement differently. In official opinions on the matter of county responsibility for medical care, the former Texas attorney general has decided that counties are responsible for all costs of indigent medical care within their boundaries, even prisoners in their jails (6).

Whether this responsibility to pay for an indigent county resident's care travels with the resident to another county may also be an issue. While the Indigent Health Care and Treatment Act says that a county shall provide medical services to each of its eligible residents, the statute does not address the issue of whether an indigent resident takes his county's obligation to pay for his care to any county through which he passes. However, former Texas attorneys general Jim Mattox (7) and Dan Morales (8) have opined that counties are responsible for the care of their indigent county residents even if the care is performed in a different county or hospital district. Thus, physicians who care for indigent patients might find it helpful to apply to the county of residence for care of an indigent patient.

Second among the criteria for eligibility of indigent patients for county coverage is the patient's resources. According to Section 61.02 of the act, counties are the payers of last resort only if other adequate public or private sources of payment are not available. In fact, if such a patient accepts county assistance and is subsequently discovered to be eligible also for another source of coverage, he or she will be responsible for reimbursing the county for the expenses that are covered. Most physicians will attempt to collect from these alternative sources in the first place, but physicians should realize that indigent residents may be eligible even if they have been denied coverage by other potential payers, such as Medicaid.

Finally, and perhaps most importantly, indigent patients must meet the income and asset limits imposed by the Indigent Health Care and Treatment Act or as modified by the county of residence. Most counties will follow the same basic considerations in assessing resources, and income of the entire household of the patient is taken into account. Medicaid recipients within the family are not considered in this equation. Furthermore, household resources are not allowed to exceed $1,000 per month, but a number of exemptions are available. Homesteads are not counted, as is $1,500 in equity in 1 vehicle, which also is exempt. The bottom line is that the net monthly income of the household residents should be about $100 per capita. "Net monthly income" means the gross monthly income, minus any work-related deductions. These work-related deductions may include up to $200 for dependent care per dependent per month, the first $90 of earnings, and $30 plus one third of the remaining earnings.

Retrieving the information to support such an equation could prove unduly burdensome on physicians who do not have adequate time or resources to audit their patients' records. Collecting the information necessary to aid the county in determining the eligibility of indigent patients is an insurmountable task for which many physicians have no time. Instead, given the complexity of the eligibility equation combined with the fast pace of patient turnover in the emergency room, emergency departments have difficulty inquiring

about all of the information that is required to fill in the eligibility equation. This is not the case for an admitting physician who is consulted or called to attend to an indigent patient in the emergency department and for whom a prolonged care and significant expense is expected.

Notice and procedural requirements
The Indigent Health Care and Treatment Act imposes procedures and deadlines for the applications process before reimbursement. Once a physician suspects that his or her patient may qualify for assistance, the physician must notify the county as soon as possible or within 3 working days after the care has been provided. To facilitate the transfer of information necessary for the county to determine eligibility, physicians are asked to submit a Form 100 for each indigent patient. Such forms are available from TDH. To speed up the process, each form should be accompanied by either a HCFA 1500 or UB 95 form. The good news is that once the application for reimbursement from the physician has been received, the county has 14 days to determine eligibility or the patient is deemed eligible under the county's indigent care program. This effectively shifts the burden onto the county to prove that the patient was ineligible for county indigent care assistance. Bureaucratic delay could result in a default decision in your favor! Once the county determines that a patient is eligible for assistance, physicians have 95 days to submit bills to the county for payment. As in the case of Medicare, these bills must be certified to show that the services billed for were medically necessary.

Health care provider's options
So, what options does a Texas physician have if the county in which he practices denies coverage on otherwise qualified indigent patients? Inquiring as to the reason for denial of coverage may or may not be especially helpful. If such an inquiry proves fruitless, the physician should ensure that the patient submitted for coverage was actually a resident of the county in which the physician practices. If not, the physician may be able to seek payment from the patient's county of residence. Next, because according to the law the county is the payer of "last resort," the physician should reevaluate whether patients who have been denied coverage actually are covered by another private or federal resource. Obviously, if another source of payment is discovered, the physician should apply to that payer for reimbursement. Finally, the physician should determine if the county has reached or surpassed its 10% expenditure of county funds allocation. In that case, the state under the CIHCP program administered by TDH maintains a fund for counties that spend more than 10% of their general revenue tax for indigent residents until the next fiscal year.

If all attempts to collect from the county or state agencies fail for an otherwise eligible indigent patient, physicians should bring pressure on the county government or hospital district for failure to provide for the health care needs of the indigents, as outlined earlier. County government is administered by the constitutional county court, which is comprised of 1 judge and the county commissioners, all of whom are elected by the general population. A lawsuit may be initiated against the hospital district or county government for payment of your fees. Note that this is a desperate measure, which is consistent with the laws of Texas but is not used routinely by an individual health care provider. As the Indigent Health Care and Treatment Act provides no mechanism for doctors whose patients have been denied legitimate coverage, physicians who wish to pursue their claims against the patient or the county should consult an attorney.

CONCLUSION

In an age where the costs and risks of practicing medicine are rising rapidly, physicians should be aware of these options in receiving payment for their services. Despite ever-increasing societal pressure to provide optimal care to all patients, these obligations to render care should not deter our pursuit of a reasonable fee. Amid recent reports concerning the inability of health care providers to collect their fees for the care they provide, note that many physicians are simply not using the Texas statutes, which give them a legal right to collect from a very important resource, the county government or hospital district where the patient resides. Private and federal assistance may account for most of the resources that physicians rely on for payment, but Texas doctors should not forget their right to county reimbursement for indigent health care nor the counties' legal duty to provide for it. Although the process often proves burdensome, only through continued pressure on our county and state leadership for reform can a more responsible and equitable system of indigent coverage be established. Until then, Texas physicians should demand payment for the services they render from the payers of last resort in Texas, the counties where the indigent patients reside.

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International Committee of Medical Journal Editors: Uniform requirements for manuscripts submitted to biomedical journals. The complete document is available in the June 1982 issue of the Annals of Internal Medicine.

Iverson C, Dan BB, Glitman P, et al: The American Medical Association Manual of Style, ed 8. Baltimore, Williams & Wilkins, 1989.

CBE Style Manual Committee: CBE style manual: a guide for authors, editors, and publishers in the biological sciences, ed 5, rev and expanded. Bethesda, Md, Council of Biology Editors, Inc, 1983.

In addition, many excellent books and manuals are devoted to principles and techniques of clear, concise writing, which are applicable to scientific as well as general topics.

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Diplomate American Board of Anesthesiology
Anesthesiology
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Suite C-538
Dallas, Texas 75230
(972) 566-4890
Answered 24 hours
Fax (972) 566-4894

Edward A. Talmage, MD, FACPM
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American Society of Bariatric Surgery
Diplomate American Board of Surgery
Surgery for Morbid Obesity & Co-Morbid Conditions
5420 Dashwood, Suite 201, Houston, Texas 77081
(713) 667-9100 Fax (713) 667-9133

Dermatology

Robert F. Bloom, MD
Mohs Surgery for Skin Cancer
Dermatologic Surgery
Malignant Melanoma
Dysplastic Nevi
Cutaneous Oncology
2201 Oxford Avenue, Suite 204
Lubbock, Texas 79410; (806) 797-6631

Gynecologic Oncology

Mark G. Doherty, MD, FACOG, FACS
Malignant and Premalignant Female Genital Disease
Texas Oncology, P.A.
7940 Floyd Curl Drive, Suite 720
Medical Center Tower II
San Antonio, Texas 78229
(210) 692-1918, Fax (210) 692-7379
Doctor's only toll-free (888) 614-2400

Hand Surgery

David J. Zehr, MD — Microsurgery
Arnold V. Dibella, MD — Wrist Derangements
Paul R. Ellis, MD
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Hand Surgery and
Upper Extremity Reconstructive Surgery
3600 Gaston Ave., Suite 450, Dallas, Texas 75246; (214) 823-5351
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Janet Macheledt, MD — Medical Oncology/Hematology
Frankie Ann Holmes, MD — Medical Oncology
Texas Oncology, P.A.
909 Frostwood, Suite 221
Houston, Texas 77024
Telephone (713) 467-1722
Fax (713) 467-1704
5618 Medical Center Drive, Suite 201
Katy, Texas 77494
Telephone (713) 392-2757
Fax (713) 392-8148

Neurological Surgery

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George F. Cravens, MD
Lee Kesterson, MD
Gregory A. Ward, MD

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Telephone (817) 336-0551

Drs. Smith and Wheeler

Ronald Smith, MD, Deceased
Joe Ellis Wheeler, MD

750 Eighth Avenue Place, Suite # 530, Fort Worth, Texas 76104
Telephone (817) 335-3966

Ophthalmology

Louis M. Alpern, MD, MPH, FACS, PA

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TexasMedicine

Here's what's coming in the February *Texas Medicine*:

Medicine in art

Needle exchange

AMA interim wrap-up

For more information, call Larry BeSaw, managing editor, at (800) 880-1300, ext. 1383, or (512) 370-1383, or e-mail larry_b@texmed.org. Also consult the TMA Web site at www.texmed.org.

Classified Directory

OPPORTUNITIES AVAILABLE

Emergency Medicine

Open Rank: BC/BE Internist Baylor College of Medicine-Houston. Faculty position for internist with an interest in Emergency Medicine and urgent care for July 1, 1999. Responsibilities include patient care, housestaff supervision, teaching, and administrative responsibilities. Clinical research is encouraged. Send CV and letter of interest to J.L. Zimmerman, M.D., 1504 Taub Loop, Houston, TX 77030. FAX (713) 799-1917. *Baylor College of Medicine is an Affirmative Action/Equal Opportunity/Equal Access Employer.*

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Seton South Community Health Center
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(512) 324-4940

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Fourth Annual Clinical Cardiology Management and Diagnostic Dilemmas. April 28-30, 1999. Santa Fe, New Mexico. Sponsored by American College of Cardiology. Program Director: John D. Rutherford, MB, ChB, FACC. Program Co-Director: Richard A. Lange, MD, FACC. 17 category 1 credit hours. For information, call 800-253-4636, ext. 695; FAX 301-897-9745.

11th Annual ADD Conference, February 5 & 6, 1999, Houston, TX. Sponsored by ADDA-SR and UT Southwestern Medical Center at Dallas. Featured speaker Sam Goldstein, Ph.D. covering current research. For physicians, psychologists, psychiatrists, and neurologists. CME credits offered. Call 281-955-3720.

Maternal/Fetal Medicine, February 12, UT Southwestern Medical Center at Dallas, Simmons Biomedical Research Building, Excellence in Education Foundation Auditorium. CME credit offered. Course director: Sue Cox, MD. Contact: Jim O'Reilly, program coordinator, (214) 641-2166.

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The following at Hilton Head Island, South Carolina:
General Surgery Update, April 7-11, 1999 • **Pediatrics Update**, April 21-24, 1999 • **General Surgery Seminar**, June 8-12, 1999 • **Adult Infectious Disease Seminar**, June 15-19, 1999 • **Pediatric Infectious Disease Seminar**, June 22-26, 1999 • **Family Practice Update & Review**, June 29-July 3, 1999 • **Anesthesiology Update**, July 6-10, 1999 • **Internal Medicine Update**, July 13-17, 1999.

The following at The Greenbrier, White Sulphur Springs, West Virginia:
Internal Medicine Seminar, October 28-31, 1999.

Call or write George M. Converse III, M.D., Lloyd Noland Foundation, 701 Lloyd Noland Parkway, P.O. Box 925, Fairfield Alabama 35064-0925 for details and brochure. Telephone: (205) 783-5276. Lloyd Noland Foundation is ACCME accredited and AMA Category I & AAFP Prescribed credit hours are offered.

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9th Annual Geriatric Psychiatry Update, February 13, UT Southwestern Medical Center at Dallas, McDermott Plaza, D1.700. CME credit offered. Course director: Kevin Gray, MD. Contact: Stacey Novotny, program coordinator, (214) 648-2166.

6th Annual Progress in Clinical Pathology, March 4-6, Le Meredian Dallas Hotel, sponsored by UT Southwestern Medical Center at Dallas. Course directors: H. Kaplan, MD; J. Keffer, MD, R. McKenna, MD. CME credit offered. Contact: Jim O'Reilly, program coordinator, (214) 648-2166.

3rd Annual Dallas Aesthetic Surgery Symposium, March 7-9, Westin Galleria Hotel and UT Southwestern Campus. Course directors: F.E. Barton, MD, H.S. Byrd, MD. CME credit offered. Contact Leah Cannon, program coordinator, (214) 648-2166.

February 19-21: Texas Neurological Society will hold its second annual Winter Conference, Austin Marriott at the Capitol. The theme is "The Cycle of Neurological Life: Therapeutics in Neurology." It will cover topics from pediatric through mid-life, to end-of-life: neuromuscular disease, headaches, epilepsy, MS, Guillian Barre, brain tumors, genetics, stroke, Parkinson's. One hour of ethics will also be offered. Contact Rachael Reed, Executive Director at (512) 370-1532, or (800) 880-1300, ext. 1532, fax (512) 370-1626, or rachael r@texmed.org.

BackTalk

Question

What could the Texas Legislature do to meet the greatest medical need in your community?

"Do the morally and ethically correct thing: develop health insurance for all children. Start now with setting the eligibility level of the Children's Health Insurance Program at 200% of the federal poverty level (though 'piecemealing' health care insurance for children is a disgrace). We found it morally and ethically correct to guarantee health insurance for everyone over age 65. Is it not imperative to achieve the same for our children? Let's put our money where our mouth is — even after elections — and let's be compassionate and moral."

Rolf W.O. Habersang, MD, 57
pediatrics, Amarillo

"The Texas Legislature could do the greatest good by staying out of the business of medicine. Legislation and regulation that mandate benefits and services increase the hassle factor for everyone."

John M. Condit, MD, 51
rheumatology, Houston

"The Texas Legislature is to be commended for enacting what are now the best regulatory statutes for health maintenance organizations in the nation. Its continued vigilance and attention to issues of medical insurance regulation is the first item of importance. Another critical area where legislators can safeguard the citizens of Texas is in defending the Medical Practice Act from the relentless onslaught of 'midlevel practitioners' seeking expanded scope of independent practice. The people of Texas should continue to receive the high quality of medical care that is our standard in Texas."

Jeffrey M. Jekot, MD, 41
anesthesiology, Austin

"The legislature should mandate that managed care organizations have medical professionals make patient care decisions — not the high school educated and other nonqualified 'clerks' from whom we now have to obtain permission to take care of patients. Often, these people cannot grasp the seriousness of a problem or even spell the words."

Kevin L. Dean, MD, 34
general surgery, Beaumont

"Close the loopholes that let managed care bypass the laws. Open access to out-of-network physicians. Allow physicians to bargain collectively as other businesses do. Managed care should be forced to at least consider approving certification for service retroactively when a precertification was not done."

Alton B. Hankins, MD, 52
psychiatry, Midland

"At the current time, our county governments are not reimbursing hospitals and physicians for indigent medical care. The legislature needs to ensure that counties pay for indigent health care."

Marshall E. Hamilton, MD, 57
pathology, Texarkana

"Societal acknowledgment of patients' rights has improved, but acknowledgment of patient responsibility has not. The legislature must empower physicians and hospitals as societal agents to limit unreasonable demands for endless and futile care."

Al Davies, MD, 46
critical care medicine, Houston

Back Talk is a nonscientific sampling of Texas physicians' opinions on a topic of interest. Physicians are polled by telephone, fax, or e-mail. We welcome suggestions for future topics. Send them to *Texas Medicine*, Back Talk, 401 W 15th St, Austin, TX 78701; fax them to (512) 370-1632; or e-mail them to m_mcever@texmed.org.

New legal remedy • Antitrust threat • Needle exchanges

Texas Medicine

Texas Medical Association

February 1999

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Courtesy Eric N. Avery, MD

The art of medicine

It's easy to forget in the current, technology-driven world of medicine that healing is an art as well as a science. And art, whether it is created by one of the masters or by a frightened child facing a serious illness, can be used by medical professionals to pass on medical knowledge to future generations, to comment on the society in which they live, and to encourage patients to express their feelings about their illnesses.

By Johanna Franke

On the cover: *Blue Smallpox: The Print of Hope* (1993). A metal plate relief print on monoprint background by professional printmaker and UTMB Galveston psychiatrist Eric N. Avery, MD, *Blue Smallpox: The Print of Hope* depicts a viral disease that killed many people but was eradicated through the concentrated efforts of physicians and scientists. Dr Avery hopes HIV and AIDS soon will be vanquished in the same manner. (Jack S. Blanton Museum of Art, The University of Texas at Austin, The Elgin W. Ware, Jr./Texas Medical Association Collection, 1997)

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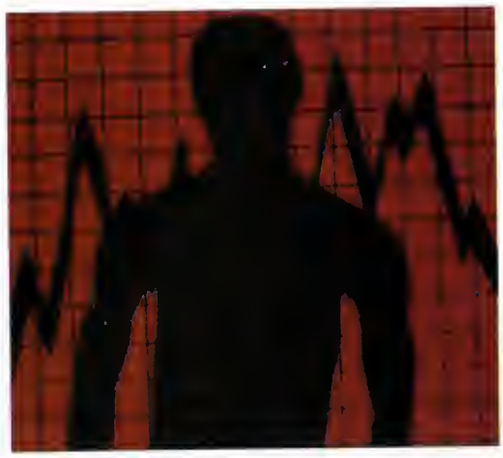

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The Big Picture

Screech owls in the backyard, by Gene E. Jones, MD, Port Arthur

If you would like to submit a photograph for The Big Picture, please send it to Laura J. Albrecht, Photo Editor, *Texas Medicine*, 401 W 15th St, Austin, TX 78701

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Letters

Americare, not profit care

Regarding the November 1998 managed care issue of *Texas Medicine,* the advantages of profit care are as illusory as "the emperor's new clothes." The temporary decrease in medical inflation during a period of low inflation and unemployment has resulted in the rationing of care by chief executive officers (CEOs) of health maintenance organizations (HMOs), a growing number of people with inadequate or no insurance at all, the loss of freedom of choice, an increase in the hassle factor, a decrease in funding for medical education and research, medical decisions being made by nonphysicians, and a huge transfer of wealth to HMO CEOs.

How did we get to this point? Physicians need to look in the mirror. Politically, organized medicine is ultraconservative; the American Medical Association was opposed to private health insurance and Medicare, so employers and politicians filled the leadership vacuum. Some say physicians need to organize to combat profit care. Physicians have too many organizations. The problem is not a lack of organization.

Organized medicine's role has been to represent the economic interests of physicians, giving lip service to other priorities such as public health. If physicians want to enjoy the practice of medicine again without the hassle of profit care, physicians need to outline goals that are compatible with a progressive society:

1. Everyone is entitled to quality, affordable health care.
2. All care is to be delivered in a timely manner.
3. National health insurance does not exclude private health insurance.
4. Physicians can be either salaried or in private practice but in any case, their report cards will be public knowledge. The same holds true for hospitals.
5. An emphasis will be placed on healthy lifestyle education.
6. An emphasis also will be placed on medical education and research.
7. Good health necessitates adequate housing, nutrition, exercise, education, and the avoidance of risky behavior such as violence and the use of drugs, alcohol, and tobacco.

These goals constitute Americare, which if adopted, would place profit care where it rightfully belongs — in the trash bin of bad historical ideas.

Gerald Frankel, MD
1441 Redbud Blvd, Ste 261
McKinney, TX 75069

Age brings experience

Freshman medical student Tobin McGowen states, "I hate to see any evidence suggesting that the problems physicians have with managed care are not about patients but about their paychecks." (See December 1998 *Texas Medicine,* p 10.)

I suggest that, should he graduate and earn his livelihood by the practice of medicine for about 10 years, he then will pay attention as to who signs his "PAYCHECK" and why.

G. Curtis Hoskins, MD
7615 St Hwy 36 E
Cross Plains, TX 76443

Express your point of view in *Texas Medicine*. To submit a letter, mail, fax, or e-mail it to *Texas Medicine*, TMA, 401 W 15th St, Austin, TX 78701; fax (512) 370-1632; e-mail larry_b@texmed.org. Please type letters you submit for publication, and keep the length to 400 words or less. If necessary, you may include a few references, preferably less than five. Letters are published at the discretion of the managing editor and editorial advisors, and are subject to editing and abridgment. Letters represent the opinions of the authors and do not necessarily reflect the policies of the Texas Medical Association.

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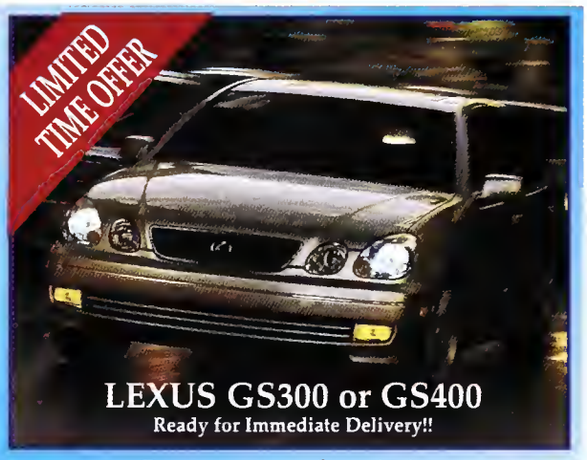

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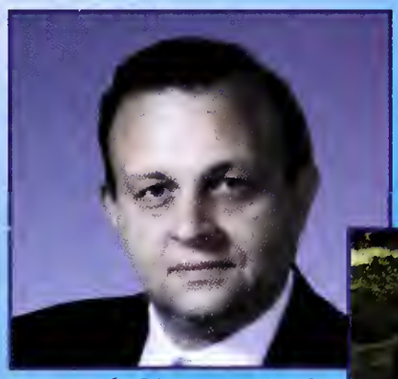

Miguel Cintron, MD
Harlingen, TX

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Miguel Cintron, MD, Harlingen, TX

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- Cross-Generational Approach to Putting Patients First by Marilyn Moats Kennedy, founder and managing partner at Career Strategies
- Tribal Warfare in Organizations by luncheon speaker Peg C. Neuhauser, president of PCN Associates, author, and management and organizational consultant
- The State's Agenda for Quality Patient Care by Texas Lt. Gov. Rick Perry (invited)
- Meeting the Needs of the State's Medicaid Patients by Texas Health and Human Services Commissioner Don Gilbert
- Obsolete Medical Staff Bylaws: What You Don't Update Can Hurt You by Elizabeth A. Snelson, JD
- Panel Session on Patient Care Issues before the 76th Texas Legislature

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People

Newsmakers

Houston rheumatologist **Frank C. Arnett, Jr, MD,** received the Mark Flapan Lifetime Achievement Award at the Scleroderma Foundation Annual Conference.

H. Randolph Bailey, MD, Houston, was named president-elect of the American Society of Colon and Rectal Surgeons.

Houston pediatric infectious diseases specialist **Carol J. Baker, MD,** was named the first recipient of the Texas Children's Hospital Foundation Infectious Diseases Endowment Chair.

Fort Worth radiologist **Mark A. Baker, DO,** was appointed to the Texas Department of Health Medical Radiological Advisory Committee.

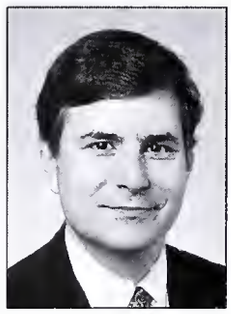
Dallas otolaryngologist **Marvin C. Culbertson, Jr, MD,** and his wife, Elizabeth, were honored with the creation of a professorship at The University of Texas Southwestern Medical School when Dr Culbertson retired after 40 years of service to the school. **Orval Brown, MD,** Dallas, was named to the Beth and Marvin C. (Cub) Culbertson Professorship in Pediatric Otolaryngology.

The 1999 Texas Society of Plastic Surgeons officers include **James Cullington, MD,** Austin, president; **Charles Verheyden, MD,** Temple, president-elect; **Rod Rohrich, MD,** Dallas, vice president; **Elizabeth Kerner, MD,** Plano, secretary; **Benjamin E. Cohen, MD,** Houston, treasurer; and **Robert Hamas, MD,** Dallas, historian.

Jesus A. Gomez, MD

Charles A. LeMaistre, MD

Richard Mabry, MD



John D. McConnell, MD

J. Dean McCracken, MD

Pedro A. Rubio, MD, PhD

Houston radiation oncologist **Luis Delclos, MD,** received the 1998 Gold Medal from the Ibero-Latin American Society of Radiation Oncologists and the Linsey Award from the National Cancer Institute in Lima, Peru.

El Paso oncologist **Jesus A. Gomez, MD,** received the Ted Spauding Award for Excellence in Graduate Education from the Department of Healthcare Administration at Trinity University in San Antonio after completing his master's degree in science and health care administration at the university.

The 1999 Harris County Medical Society officers include internist **Carlos Hamilton, Jr, MD,** Houston, president; neonatal-perinatal medicine specialist **Michael Speer, MD,** Houston, president-elect; general surgeon **Phillip Sutton, MD,** Houston, vice president; and emergency medicine specialist **Diana Fite, MD,** Waller, secretary-treasurer.

Charles A. LeMaistre, MD, Austin, received the American Cancer Society's Medal of Honor for Distinguished Service in Cancer Control. Before his retirement, Dr LeMaistre was president of The University of Texas M.D. Anderson Cancer Center in Houston.

Please let *Texas Medicine* know about your honors and achievements. Criteria for inclusion in the Newsmakers section are TMA membership; election or appointment to an office of, or honors from, a national or state organization; or, space permitting, recognition at the local level. Items for the Newsmakers section are published at the discretion of the managing editor. Submit items for consideration, with photos if possible, to Johanna Franke, People, *Texas Medicine*, 401 W 15th St, Austin, TX 78701; fax (512) 370-1632; e-mail johanna_f@texmed.org.

Richard Mabry, MD, Dallas, received the Pen and Scroll Award from the American Academy of Otolaryngic Allergy.

Fort Worth internist **Alvin I. Mathé II, DO,** was appointed medical director of the Wound Healing and Hyperbaric Medicine Center at the Osteopathic Medical Center of Texas.

John D. McConnell, MD, Dallas, was named to the American Urological Association Board of Directors.

J. Dean McCracken, MD, San Antonio, was elected president of the Texas Society of Medical Oncology.

Dallas pathologist **Philip O. Montgomery, MD,** received the Aesculapius Award from the Dallas County Medical Society.

Dallas pediatrician **William H. Moore, MD,** won the Dallas White Rock Marathon and qualified for the US Olympic Trials.

Urologist **Lewis E. Pope, MD,** was named physician of the year by the Arlington Medical Society.

Porter general surgeon **Pedro A. Rubio, MD, PhD,** received the Golden Paracelsus Medal Pro Merito from the St Andrew Association of the Chivalrous Order of St Andrew in Scotland.

Center Point addiction medicine specialist **Francis Seale, MD,** was honored by Kerrville Mayor Ben Low's designation of October 26, 1998, as "Dr Francis Eugene Seale Day" in recognition of Dr Seale's leadership and dedication in the field of substance addiction.

Tyler radiologist **Joseph Selman, MD,** received the Smith County Medical Society's 1998 Gold-Headed Cane Award.

Fort Worth surgeon **Adam Smith, DO,** was elected vice president of the Texas Osteopathic Medical Association.

Michael Speer, MD, Houston, was elected to the Executive Committee of the Perinatal Section, American Academy of Pediatrics, District 7.

Family practice-sports medicine specialist **Alan Stockard, DO,** was named director of a new sports medicine residency training program at the University of North Texas Health Science Center in Fort Worth.

James C. Thompson, MD, Galveston, was named president-elect of the American College of Surgeons.

Temple anesthesiologist **Frank J. Villamaria, MD,** was elected to the Scott and White Clinic Board of Directors as an associate.

Lubbock general surgeon **Gerald L. Woolam, MD,** received the Award of Hippocrates from the Lubbock-Crosby-Garza County Medical Society.

Deaths

Edgar Henry Allen, Jr, MD, 71; Marshall; Baylor University College of Medicine, 1954; died November 28, 1998.

Thomas Patrick Buckley, MD, 69; Dallas; Hahnemann University School of Medicine, 1959; died November 19, 1998.

Donald Campbell, MD, 83; San Antonio; Cornell University Medical College, 1940; died November 30, 1998.

Loren Bruce Goss, MD, 68; Tyler; University of Iowa College of Medicine, 1955; died November 20, 1998.

Gerald Houghton Jordan, MD, 93; Sterling, Va; University of Western Ontario, 1929; died November 12, 1998.

Gonzalo Lopez, MD, 58; Irving; Universidad Nacional de Cuyo-Mendoza, Argentina, 1965; died December 14, 1998.

Thomas Sterling Martin, MD, 77; El Paso; Northwestern University Medical School, 1946; died November 18, 1998.

Otto Munoz, MD, 61; Lubbock; The University of Texas Southwestern Medical School at Dallas, 1965; died November 11, 1998.

William Horton Nash, MD, 70; San Antonio; The University of Texas Medical Branch at Galveston, 1958; died November 15, 1998.

Thomas Andrew Rogers, MD, 46; El Paso; The University of Texas Medical Branch at Galveston, 1985; died November 15, 1998.

Ruben Conrado Santos, MD, 65; McAllen; University of Nuevo Leon Medical School-Mexico, 1954; died November 7, 1998.

Miles Eugene Sedberry, Jr, MD, 76; Austin; The University of Texas Medical Branch at Galveston, 1951; died December 2, 1998.

Walter Baldwin Shelton, Jr, MD, 74; Temple; The University of Texas Medical Branch at Galveston, 1958; died November 19, 1998.

Wayman Rutherford Spence, MD, 64; Waco; University of Oklahoma College of Medicine, 1960; died December 6, 1998.

Vance Terrell, MD, 90; Stephenville; The University of Texas Medical Branch at Galveston, 1932; died November 6, 1998.

George Marion Waddill, Jr, MD, 90; Amarillo; The University of Texas Medical Branch at Galveston, 1932; died November 18, 1998.

Going The Extra Mile For The Referring Physician: Cook Children's Talks With Dr. W. Paul Bowman.

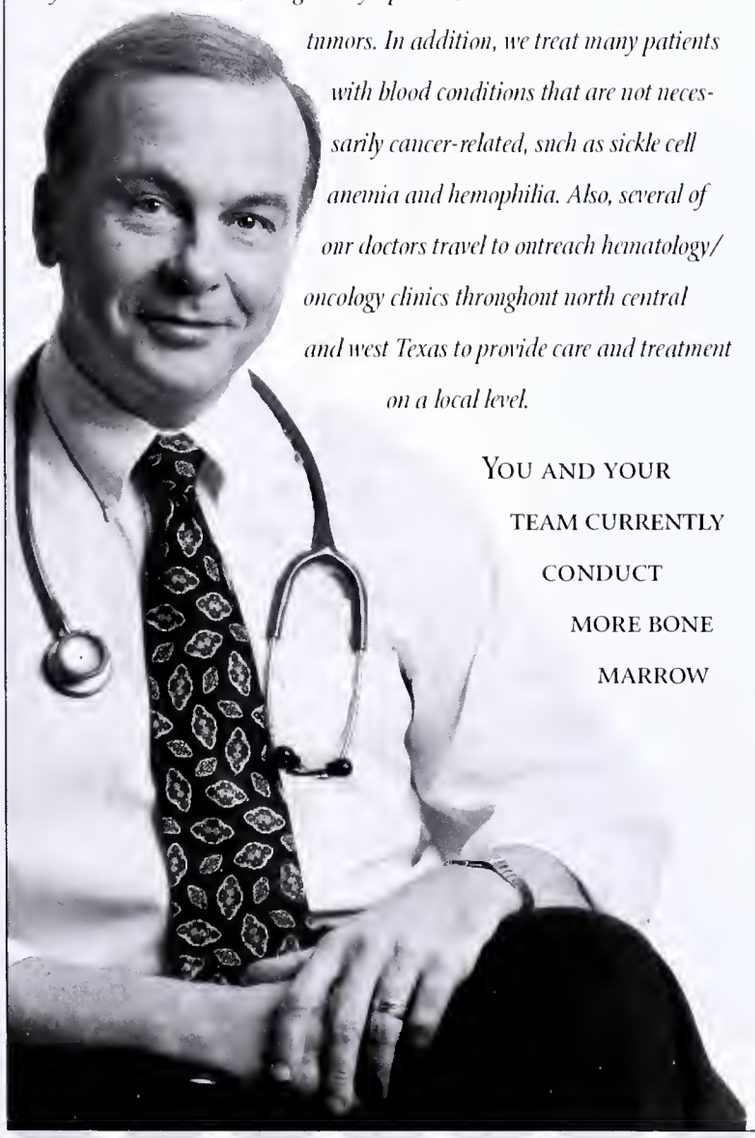
DR. W. PAUL BOWMAN — MEDICAL DIRECTOR OF HEMATOLOGY/ONCOLOGY

DR. BOWMAN, WHAT TRENDS ARE YOU SEEING IN THE FIELD OF PEDIATRIC HEMATOLOGY/ONCOLOGY?

Significant strides have been made in the treatment of childhood cancer. Today, more than 70 percent of the children newly diagnosed with cancer can be expected to enjoy a relatively long life and possibly even see a cure for their disease.

WHAT TYPES OF DIAGNOSES ARE YOU ABLE TO TREAT GIVEN THE SCOPE OF SERVICES, CLINICAL EXPERTISE AND RESOURCES AVAILABLE AT COOK CHILDREN'S?

We're able to provide care for patients who are afflicted with a wide range of illnesses: leukemia, malignant lymphoma, brain tumors and solid tumors. In addition, we treat many patients with blood conditions that are not necessarily cancer-related, such as sickle cell anemia and hemophilia. Also, several of our doctors travel to outreach hematology/oncology clinics throughout north central and west Texas to provide care and treatment on a local level.



YOU AND YOUR TEAM CURRENTLY CONDUCT MORE BONE MARROW TRANSPLANTS THAN ANY OTHER CHILDREN'S HOSPITAL IN TEXAS AND SURROUNDING STATES. WHAT DO YOU THINK SETS YOU APART FROM OTHER CHILDREN'S HOSPITALS?

In 1986, we opened the first pediatric bone marrow transplant program in the region and have had very good success. Our center is approved by the National Marrow Donor Program as a registry, collection, and transplant center. We perform both allogeneic and autologous transplants, as well as utilize unrelated donors for patients lacking a family match.

DR. BOWMAN, WHAT IS IT THAT A REFERRING PHYSICIAN WANTS MOST TO GET OUT OF HIS OR HER RELATIONSHIP WITH A SPECIALIST?

He or she wants to know that the patients and their families will be provided with the best care available; that they will have a positive experience, and have confidence in the treatment team. He or she wants to be kept apprised of the patient's status, stay involved in the follow-up care, and provide support to the family.

COOK CHILDREN'S IS AN INDEPENDENT COMMUNITY-BASED HEALTH CARE SYSTEM, COMBINING THE BEST IN PATIENT CARE WITH RESEARCH. HOW DOES THIS BENEFIT THE PATIENT?

We provide patients with the best of both worlds – treatment and research. We focus primarily on the clinical aspects of the patient's care and also participate in ongoing research programs. We believe we are in the best position to offer greater continuity of care, since taking care of the patient is our number one concern.

Cook Children's Medical Center is located in Fort Worth, Texas. For more information about Dr. Bowman and our other pediatric oncologists – Gretchen Eames, David Friedman, Timothy Griffin, Jeffrey Murray, Joann Sanders, Ami Slah, Juan Bernini in Midland/Odessa and Benjamin Carcamo in El Paso – call 1-800-COOK517.

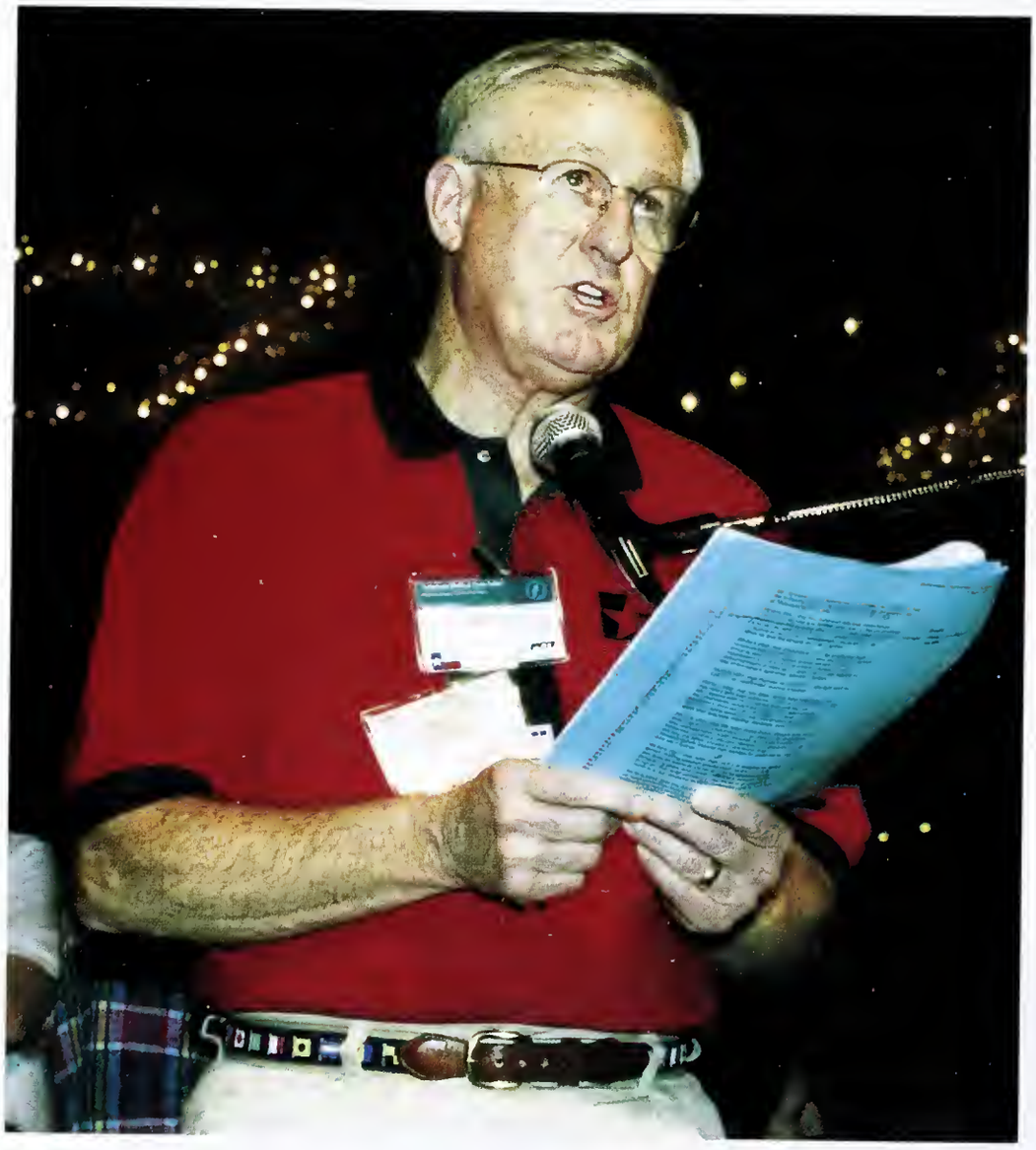
CookChildren's
Medical Center

Texas Medicine Rounds

By Johanna Franke

AMA interim report

Delegates reaffirm stance on E/M guidelines, push for antitrust reforms, revamp AMA governance



Arlington general surgeon Bohn D. Allen, MD, chair of TMA's Council on Socioeconomics, addresses the American Medical Association House of Delegates in December.

By Steve Levine

With leadership from the Texas delegation, the American Medical Association House of Delegates adopted a strong resolution on fraud and abuse and Medicare evaluation and management (E/M) documentation guidelines at its interim meeting December 6–9 in Honolulu. The AMA action came on the heels of an equally strident resolution passed by the Texas Medical Association House of Delegates a month earlier.

Arlington general surgeon Bohn D. Allen, MD, said the delegation's "marching orders from the folks back home" demanded that the AMA House adopt clear and unambiguous policy on the issue. Specifically, the delegates:

- Called on the AMA to "express outrage that the practice of medicine is characterized as abusive and fraudulent";
- Adopted a statement that America's physicians have had enough of unfair fraud and abuse enforcement and will not stand for harassment by auditors or unwarranted accusations of abusive and fraudulent behavior;
- Reaffirmed the House's opposition

to "numeric counting systems" in the medical record and called on the Health Care Financing Administration (HCFA) to replace random audits with a focused review program that includes peer review of statistical outliers;

- Instructed the AMA Board of Trustees to continue technical assistance to HCFA through the CPT Editorial Panel to produce simpler, patient-centered, clinically relevant, and nonintrusive guidelines; and
- Left to the board the question of whether to seek legislative remedies "if negotiations with HCFA are unsuccessful in implementing all applicable AMA policies."

"The underlying driving fear is that physicians are subject to fines and penalties and being kicked out of Medicare over trivial differences in documentation," said Dr Allen, chair of TMA's Council on Socioeconomics. "That's why TMA has particularly been insistent that any guidelines focus on medical necessity and medical decision-making."

In related action, the AMA House urged HCFA to eliminate the Payment Error Prevention Program, including so-called "bounties" that would be paid to Medicare peer review organizations that identify overpayments.

Managed care response

Much of the discussion over how AMA can help physicians better manage managed care focused on federal antitrust laws' diminution of physicians' bargaining power when negotiating with health plans. The House directed the AMA to continue to seek legislative relief for physicians from over-broad application of the antitrust laws.

Delegates also called for state and federal legislation to hold health plans' medical directors liable for their medical decisions "regarding contractually covered services." The House approved a 1999 AMA budget that included an increase of more than $1 million for private sector advocacy efforts that "respond to the tremendous growth in demand for action" on managed care policies, contracting, and grievance issues.

AMA structure reform

The House adopted the extensive and often-scathing report from the Ad Hoc Committee on AMA Structure and Governance largely as delivered. The committee was created amid the fallout of AMA's 1997 Sunbeam scandal. House action on the report included these highlights:

- AMA bylaws will be amended so that the chair of the board will be precluded from running immediately for the position of president-elect. The bylaws will denote a chair and chair-elect as officers of the board, each limited to one 1-year term, with the chair-elect automatically succeeding the chair. No AMA officer or trustee will be eligible to serve as executive vice president within 3 years of leaving office;
- The board and all AMA councils will regularly measure their meetings and all new initiatives against the goals of the AMA strategic plan; and
- A special committee of the House will determine the structure of compensation and establish the amount of compensation for the AMA Board of Trustees annually. A recommendation to diminish significantly the public appearances of board members was rejected in favor of an independent evaluation of the value of the appearances.

"The House action sent a message to the Board of Trustees, and it's not necessarily a hostile message," said William G. Gamel, MD, chair of the Texas Delegation to the AMA. "The House sent a positive message of constructive criticism to correct some inefficiencies in the board's operations and to help prevent the board from being perceived as overstepping its bounds or responsibilities."

Other issues merit action

More than 50 Texas physicians representing TMA, various sections, and national specialty societies participated in the AMA meeting. The House adopted two of the three resolutions carried by the Texas doctors, whose members included Nancy W. Dickey, MD, of College Station, AMA's first woman president.

Dr Dickey called on the organization to become "the national champion" for universal access to health care. The AMA president said it is "our highest priority . . . to make sure that every patient in every community in America has access to care and a way to pay for it, no matter who they are, no matter what they do, no matter how much — or how little — they earn." A recent *American Medical News* article, which reported that the number of Americans without health insurance grew by more than 1.7 million during 1997, also noted that Texas' 26.7% uninsured is the nation's third highest.

Delegates addressed various other economic, legislative, public health, and organizational topics. The House:

- Adopted a resolution reaffirming that "anesthesiology is the practice of medicine";
- Adopted the policy that the first priority for funds that states receive from the settlement of lawsuits against tobacco companies should be for expanding tobacco cessation and prevention programs and for the "treatment of diseases related to nicotine addiction and tobacco use";
- Voted to strongly oppose any attempts to legalize physician-assisted suicide or euthanasia;
- Urged the AMA to develop recommendations regarding the number of US medical school graduates "consistent with appropriate workforce needs";
- Directed the AMA to seek repeal of HCFA's authority to require physi-

"The underlying driving fear is that physicians are subject to fines and penalties and being kicked out of Medicare over trivial differences in documentation."

cians to submit diagnosis codes with every claim for a lab test;

- Directed the Council on Ethical and Judicial Affairs to reconsider its recommendation prohibiting physicians from leaving test results on patients' answering machines without their prior consent;
- Adopted a universal definition of "medical necessity";
- Adopted recommendations for screening and surveillance for colorectal cancer;
- Rejected a resolution calling on the AMA to support legislation for the increased use of automatic external defibrillators; and
- Called on the AMA to develop and distribute educational materials on domestic violence, partner abuse, and date violence for junior high and high schools.

More than 50 Texas physicians representing TMA, various sections, and national specialty societies participated in the AMA meeting.

Action on Texas resolutions

The Texas delegation carried three resolutions to Honolulu. The House incorporated one of the proposals into its statement on E/M guidelines.

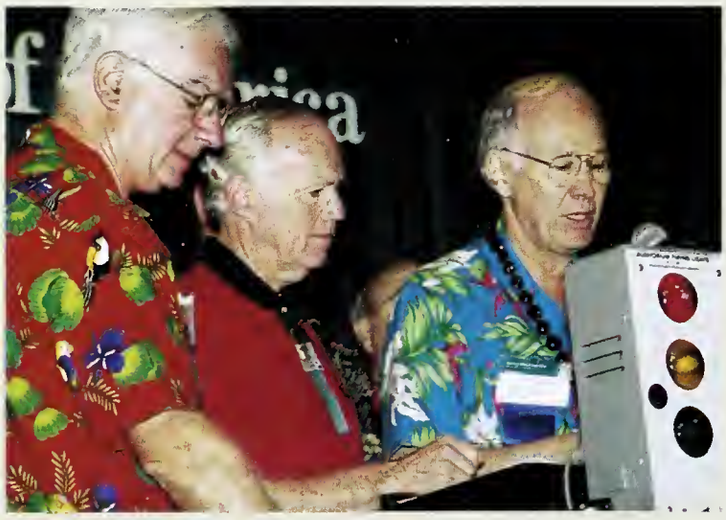
Delegates also adopted a Texas resolution calling on the AMA to support legislation against carriers or payers who use "unreasonable business practices to unilaterally downcode or inappropriately bundle physician services."

The third Texas resolution called on the AMA to urge pharmaceutical companies to stop using confidential prescription drug profiles for marketing purposes. Delegates decided that the problem is not yet well-enough defined and asked the board to complete a study of the issue by AMA's 1999 annual meeting in June. ★

Live & Then Give goes national

Dallas orthopedic surgeon Phil H. Berry, Jr, MD, has done a tremendous amount of living since that 1986 day when he found himself staring death in the face. Thanks to a liver transplant, Dr Berry survived liver failure and has lived to enjoy his three daughters' weddings, three precious grandchildren, two holes in one, service as president of the Texas Medical Association, and the creation of an award-winning organ donor awareness program.

In December, Dr Berry took that Live & Then Give program 3,800 miles across the Pacific Ocean to Honolulu, where he helped the American Medical Association launch a national version of Live & Then Give. Just as he has with hundreds of Texas audiences over the past few years, Dr Berry shared with the AMA House of Delegates his moving story of the 30-year-old South Texas housewife who died of a bleeding aneurysm and gave him "the ultimate gift of life."



Speaker of the American Medical Association House of Delegates Richard F. Corlin, MD, Santa Monica, Calif, left, and Texas Medical Association Immediate Past President Phil H. Berry, Jr, MD, Dallas, center, look on as AMA Board of Trustees Chair Randolph D. Smoak, Jr, MD, Orangeburg, SC, right, signs an organ donor card as part of AMA's Live & Then Give initiative.

The delegates responded with a mass organ donor card-signing ceremony, which Dr Berry hopes will be the start of a nationwide effort by America's physicians to help bridge the gap that has created a 60,000-person-long waiting list for human organs in this country. The AMA's Live & Then Give initiative includes a video, brochures, and other educational materials. Like the TMA program, it's aimed primarily at physicians, their families, and their staffs. In addition to the delegates' efforts, the AMA Medical Student Section joined the national Live & Then Give initiative by adopting the program as the section's community service project. During AMA's interim meeting, about 100 medical students, including several Texans, donned scrubs and hit Honolulu beaches and a local mall to discuss the importance of organ donation. Their efforts reached an estimated 800 to 1,000 people.

Dr Berry reminded the delegates of the recent news reports that hepatitis C now infects about 170 million people worldwide, 4 million in the United States. In 10 years, he says, it's estimated the need for liver transplants will increase 523%.

"If there ever was a white-hat issue for us to pursue, this is it," Dr Berry told the AMA House. "When we put patients first, we always win, along with our patients."

Tool to measure patient satisfaction

As part of Texas Medical Association's "Putting Patients First" initiative, TMA is providing you with a tool to gauge your patients' happiness with your work in the form of an insert in this issue of *Texas Medicine* (between pp 16 and 17).

The survey, reprinted with permission from Stratis Health's Patient Satisfaction Measurement Program, allows patients to rate many aspects of their doctors' appointments, from office location convenience to the technical skills and personal manner of you and your office staff. On the reverse side of this special *Texas Medicine* insert, you will find advice on how to improve your practice based on the data you've collected.

Take advantage of this chance to refine your practice, track quality improvement over time, and obtain feedback from your patients! They'll be glad you did. ★

Marilyn Moats Kennedy

Don Gilbert

Elizabeth A. Snelson, JD

Peg C. Neuhauser

Leadership conference focuses on patients

Patient care — from the medical office to the state legislature — dominates the program topics at Texas Medical Association's 1999 Winter Leadership Conference February 27 at the Renaissance Austin Hotel.

TMA President John P. Howe III, MD, will kick off the conference with his presentation "Putting Patients First: Opportunities and Challenges," followed by American Medical Association Executive Vice President E. Ratcliffe Anderson, Jr, MD, with his discussion "Guiding Our AMA to an Environment of Quality and Values."

Marilyn Moats Kennedy, founder of the 21-year-old Wilmette, Ill, consulting firm Career Strategies, will present a cross-generational approach to putting patients first, while Texas Health and Human Services Commissioner Don Gilbert will discuss the needs of the state's Medicaid patients. A TMA Council on Legislation panel will give an update on patient care issues before the 76th Texas Legislature to round out the conference's general session, which begins at 9:30 am. Lieutenant Governor Rick Perry has been invited to discuss the state's agenda for quality patient care as well.

And winter leadership attendees won't want to miss valuable presentations before and after the general session. Medical staff attorney Elizabeth A. Snelson, JD, will present the 7:30 am "dawn duster" session titled "Obsolete Medical Staff Bylaws: What You Don't Update Can Hurt You." Each attendee will receive a copy of Ms Snelson's new book *Physicians' Guide to Medical Staff Organization Bylaws* at the 2-hour session sponsored by the TMA Organized Medical Staff Section. Peg C. Neuhauser, author of *Tribal Warfare in Organizations* and president of PCN Associates in Austin, will provide some communication and conflict management pointers during the conference luncheon sponsored by the Texas Medical Association Insurance Trust. After lunch, a special 2-hour afternoon program presented by Ms Kennedy will provide insight to improve outcomes with patients, staff, colleagues, family, and friends from multiple generations.

TMA committee, council, board, and section meetings will be held February 24–27 in Austin in conjunction with the conference, along with a special reception February 26 from 5:30 to 7 pm. The conference, including the "dawn duster" session, the luncheon, and the afternoon session, has been approved for 7 hours of AMA PRA Category 1 continuing medical education credit. Registration is free for TMA members and invited guests, and $200 for nonmember physicians. For more information, call Amy Edwards, TMA special services, at (800) 880-1300, ext 1346, or (512) 370-1346; or e-mail amy_e@texmed.org. ★

Retired otolaryngologist Ernest Butler, MD, and his wife, Sarah, of Austin, gave Texas science teachers a boost through a $30,000 donation to the Texas Medical Association Foundation.

Physician treasures teachers through gift to TMAF

Texas Medical Association Foundation (TMAF) board member Ernest Butler, MD, and his wife, Sarah, of Austin, have made a significant donation to TMAF, and, in doing so, a meaningful contribution to the education of future physicians.

The Butlers' generous gift of $30,000 will be used to establish an endowment that supports TMA's Excellence in Science Teaching Awards, which are annual honors given to outstanding science teachers at the elementary, middle, and high school levels. "Teachers can be such a positive stimulus in a student's life," said Dr Butler, TMAF treasurer and retired otolaryngologist.

Longtime philanthropists, the Butlers have made major donations to The Blood and Tissue Center of Central Texas and the Austin Museum of Art. Dr Butler, who formerly served on the boards of the Travis County Medical Society and Texas Medical Foundation, is a board member of the Austin Community Foundation, Austin Symphony Orchestra, and Austin Museum of Art.

For information on how to make additional contributions to the endowment, contact TMAF at (800) 880-1300, ext 1664, or (512) 370-1664. ★

TMAF elections result in new treasurer, member

One Austin physician has joined the Texas Medical Association Foundation (TMAF) Board of Trustees while another Austin physician has accepted additional board duties as treasurer.

Retired internist Robert Bernstein, MD, former commissioner of health for the Texas Department of Health from 1980 to 1991, was elected a TMAF board member, while retired otolaryngologist Ernest Butler, MD, was elected treasurer of the board.

The mission of TMAF, the philanthropic arm of the Texas Medical Association, is to fund initiatives with the power to help physicians create a healthier future for all Texans. ★

Public health partnerships earn community grants

The Ropes Course Project of Odessa, left, and the National Marrow Donor Program of Fort Worth, right, recently received funds earned through the Texas Medical Association Foundation (TMAF) community grants program. Ropes Course Project participants pictured with TMAF board member Nalin H. Tolia, MD, center, are Susan Leshnower, president of the Ector County Medical Alliance, left, and Julia Gaggin, director of Harmony Home Children's Advocacy Center, right. The Ropes Course Project treatment strategy is to help build self-esteem, trust, and confidence among children who are victims of sexual abuse. National Marrow Donor Program participants pictured with TMAF board member Beverlee Herd, second from left, are Teresa Oltersdorf, president of the Tarrant County Medical Society Alliance (TCMSA) Foundation, left; Gloria Saenz, chair of TCMSA's Live & Then Give program, second from right; and Linda Dorton, representative from the National Marrow Donor Program at Cook Children's Medical Center, far right. The program is an initiative to tissue type potential bone marrow donors so that more successful matches can be made for patients in need. The new TMAF community grants program awarded funds last year to seven projects that will be conducted through partnerships between community and health-related organizations and county medical, alliance, and specialty societies.

WEB SITES OF INTEREST TO TEXAS PHYSICIANS BY JOHANNA FRANKE

MedBytes

TMA Web wizards recently have made several improvements to TMA's Web site at www.texmed.org. Here are just a few.

Find a Texas physician

Point prospective patients to the TMA site when they need to know basic information about you such as a map to your office, your phone and fax numbers, the medical school you attended and your graduation date, and your TMA and AMA member status. The "Find A Member" section under "About TMA" in the public section of the TMA Web site allows visitors to search for a Texas physician by last name, specialty, city, or county medical society. The search produces a summary of the above information plus a physician's gender, specialty, and county medical society.

Earn stroke CME credit online

Physicians can now gain 3 hours of continuing medical education (CME) credit by completing the Texas Medical Association Stroke Program online. To access the program, go to the "Health & Science" area of the TMA Web site and select "Special Projects in Public Health and Quality." Then select "TMA Stroke Project" and follow the directions from there. This CME program, sponsored by the Texas Medical Association Stroke Project, is designed to educate physicians, nurses, and other health care professionals about stroke prevention, care, and treatment.

Online specialty societies are on the move

Tired of typing in a mile-long address to find your specialty society on the Internet? TMA's Association Management Services (formerly known as Specialty Society Management Services) has made the process of finding TMA-hosted specialty sites much simpler.

If your specialty society is listed below, just type in TMA's Web address plus a slash and the first letter of each main word in your society's name to get the latest online news on your specialty. If you don't want to keep up with several society Web addresses, go to the TMA site at www.texmed.org, select "Other Medical Sites," and then "Specialty Societies" for links to most of Texas' specialty societies with Internet sites.

Texas Association of Physicians in Nuclear Medicine	www.texmed.org/tapnm
Texas Dermatological Society	www.texmed.org/tds
Texas Geriatrics Society	www.texmed.org/tgs
Texas Neurological Society	www.texmed.org/tns
Texas Radiological Society	www.texmed.org/trs
Texas Society of Gastroenterology & Endoscopy	www.texmed.org/tsge
Texas Society of Medical Oncology	www.texmed.org/tsmo
Texas Society of Pathologists, Inc	www.texmed.org/tsp
Texas Society of Plastic Surgeons	www.texmed.org/tsps
Texas Transplantation Society, Inc	www.texmed.org/tts
Texas Urological Society, Inc	www.texmed.org/tus

MedBytes is a quick look at new, or newly discovered, Web sites of interest to Texas physicians. The column also highlights features of the TMA Web site at www.texmed.org. If you know of some cool medical sites or have questions about how to use the TMA Web site, e-mail johanna_f@texmed.org. Publication of information about Web sites in this column is not to be considered an endorsement or approval by the Texas Medical Association of the sites or sponsors, or of any products or services involved.

COUNTRY MANOR SHAKE

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Reserve your place at TexMed '99 events

What do a Ross Perot presentation, a culture bus tour, and a visit to the Heard Natural Science Museum and Raptor Rehabilitation Center have in common? They're all activities in which you can participate during Texas Medical Association's TexMed '99, May 6–9 at the Wyndham Anatole Hotel in Dallas.

Finish off your first day at TexMed with a presentation by a most famous Texan — Ross Perot — during the TMA Alliance's Dallas World Aquarium Dinner from 6:30 to 10 pm on May 6. Your children can participate in special activities on their own while you enjoy a fine dinner in casual, comfortable attire.

On May 8, soak up some culture by catching a bus. TexMed's Culture Bus Tour will take you to the middle of Fort Worth's cultural district, from which you can walk to the Kimbell Art Museum, Amon Carter Museum, the Will Rogers Memorial Complex, the Fort Worth Museum of Science and History, and the Modern Art Museum of Fort Worth. When you're ready for a change of pace, the bus will be making runs from the museum district to Fort Worth's Sundance Square, where more than 20 restaurants, 20 retail shops, 2 movie theatres, and 5 live theatres and galleries await you.

If you're looking for an outdoor experience, you'll want to catch the bus to the Heard Natural Science Museum and Wildlife Sanctuary in McKinney, where you can hike the nature trails and participate in a presentation on the rehabilitation process for injured birds of prey. Or perhaps a lively game of tennis is more your speed. If so, grab your racquet and head over to the Wyndham Anatole Hotel's Verandah Club during the afternoon on May 8.

And don't forget TexMed '99 events sponsored by the TMA Foundation, including the 1999 C. Lincoln Williston Golf Tournament on May 5 and the "New York Nights" benefit on May 7. For more information on these events or on-site child care or to reserve a space for these activities, watch for your TexMed '99 registration form in the mail. ★

In Case You Missed It

By Melissa McEver

Poor literacy skills can take their toll on a person's health, a new study has found. Researchers at CASE WESTERN RESERVE UNIVERSITY in Cleveland gave a health literacy test to more than 900 emergency room patients, measuring their ability to understand directions and prepare for procedures. The researchers then kept track of how often the patients were hospitalized. The odds that patients with poor medical literacy would be hospitalized were significantly higher than those of the patients deemed adequately literate.
(*Journal of General Internal Medicine*, 12/98)

A nut a day may keep heart troubles away. Researchers at the HARVARD SCHOOL OF PUBLIC HEALTH have found that eating nuts can lessen the risk of heart disease. The scientists discovered that women who ate nuts more than five times a week for 10 years were one-third less likely to develop heart problems than other women.
(*British Medical Journal*, 11/14/98)

The belief that merely wearing sunscreen protects against skin cancer may be an illusion, a recent study by the EUROPEAN ORGANIZATION FOR RESEARCH AND TREATMENT OF CANCER MELANOMA COOPERATIVE GROUP has revealed. Scientists found in their survey of 631 school children that the children with the highest use of sunscreen were the most likely to have sun-caused moles, a predictor for skin cancer later in life. The researchers speculated that this effect occurred because wearing sunscreen is associated with increased sun exposure. They recommended that people continue to use sunscreen but also wear protective clothing and keep sun exposure moderate.
(*Journal of the National Cancer Institute*, 12/16/98)

The teenagers of today are somewhat healthier than the teens of the 1960s, researchers have discovered. Scientists at the NATIONAL INSTITUTES OF HEALTH found that teenagers in the 1990s have showed a 4% drop in their cholesterol levels from those of adolescents 30 years ago. Teens' daily fat consumption also has dropped from 37% to 34% of total calories. The decline is minimal, but it still could have a significant impact on the teens' risk of heart disease later in life, the researchers reported.
(*Preventive Medicine*, 12/98)

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TexasMedical Association

PHYSICIAN ONCOLOGY POEP EDUCATION PROGRAM

TEXAS CANCER COUNCIL

Research recognizes health differences between sexes

The Society for the Advancement of Women's Health Research has pinpointed 10 gender differences concerning disease epidemiology and health outcomes through gender-based biology, the field of scientific inquiry committed to identifying the biological and physiological differences between men and women. The society's 10 "differences that make a difference" are:

- **STDs** — Women are two times more likely than men to contract a sexually transmitted disease and 10 times more likely to contract HIV during unprotected sex with an infected partner.
- **Depression** — Women are two to three times more likely than men to suffer from depression, in part because women's brains make less of the chemical serotonin.
- **Osteoporosis** — Women comprise 80% of the population suffering from osteoporosis, which is attributable to a higher rate of lost bone mass in women.
- **Lung cancer** — Women smokers are 20% to 70% more likely to develop lung cancer than men smokers.
- **Heart disease** — Women are more likely than men to have a second heart attack within a year of the first one.
- **Anesthesia** — Women tend to wake up from anesthesia more quickly than men (an average of 7 minutes for women and 11 minutes for men).
- **Drug reactions** — Even common drugs like antihistamines and antibiotics can cause different reactions and side effects in women and men.
- **Autoimmune diseases** — Three out of four people suffering from autoimmune diseases such as multiple sclerosis, rheumatoid arthritis, and lupus are women.
- **Alcohol** — After consuming the same amount of alcohol, women have a higher blood alcohol content than men.
- **Pain** — Some pain medications (known as kappa-opiates) are far more effective in relieving pain in women than in men. ★

CONNECT TO TMA

HotLines

TMA switchboard (800) 880-1300

Impaired physicians (800) 880-1640
Call this 24-hour hotline to report information concerning physicians who may be abusing alcohol or other drugs, or who may be chemically addicted, psychiatrically impaired, or have other problems. All calls are confidential.

Insurance (800) 880-8181
The Texas Medical Association Insurance Trust offers life, health, disability, office overhead, personal accident, and other insurance plans and products to TMA members, their families, and office staffs.

Loans (800) 880-2828
TMA offers qualified medical students and residents low-interest loans. Call for general requirements and application procedures.

TEXPAC (800) 880-1300, ext 1362
The TMA Political Action Committee speaks on behalf of physicians through grassroots involvement, personal relationships with elected officials, and political campaign participation and contributions.

TPSO (800) 523-8776
The Texas Physician Services Organization delivers physicians and physician organizations an array of products and services to help them succeed in the changing medical marketplace.

Use the following prefixes plus @texmed.org to e-mail for TMA resources.

General Information	info
Continuing Medical Education	cme
Interspecialty Society Committee	isc
Medical Education	meded
Member Services	memberservices
Meeting Management	meetings
Physician Oncology Education Program	poep
Sneak Preview	sneakpreview
Specialty Societies	ssms
TMA Alliance	tmaa
TMA Bookstore	bookstore
TMA Library	tma_library
Texas Physician Services Organization	tpso

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Medicaid providers reminded to reenroll

Medicaid providers have until September to reenroll with the National Heritage Insurance Company (NHIC) but are strongly encouraged by NHIC to return completed packets quickly. After June 1, NHIC cannot guarantee that packets will be entered into the new database before the September 1 cutoff. Providers who fail to return a completed reenrollment form by September will be disenrolled from the program. Physicians who currently have multiple provider numbers received duplicate packets, though only one must be returned. The exception is for some group-based physicians who practice at multiple locations.

This initiative is driven by Senate Bill 30, which was enacted by the Texas Legislature in 1997 and obliges providers to sign a new agreement stipulating that they will comply with the state's Medicaid program integrity efforts. For questions about the reenrollment process or if you did not receive a form, contact NHIC customer relations at (800) 925-9126. ★

More time in church means less time in hospitals

Older patients with some religious affiliation cut down their hospital stays by more than half, according to a Duke University Medical Center study. Patients age 60 or older with no religious connection spent an average of 25 days in the hospital compared with the 11 days spent by patients with some religious association. Those who attended weekly religious services were 56% less likely to have been hospitalized the previous year compared with those who attended less frequently.

The study, which was published in the October 1998 *Southern Medical Journal*, examined the relationship between religious participation and affiliation and acute hospital services in 542 patients aged 60 or older consecutively admitted to Duke University Medical Center. ★

POEP ethics talks come to your neighborhood

TMA's Physician Oncology Education Program (POEP) has hit the highway to bring you the latest cancer information and a chance to fulfill that 1 formal continuing medical education hour in medical ethics and/or professional responsibility.

PHYSICIAN ONCOLOGY
POEP
EDUCATION PROGRAM

With 60 to 90 days' notice, POEP will put together an ethics "on-the-road" talk for your county medical society or hospital covering either cancer pain management or genetic evaluation of cancer. The cancer pain management lecture includes discussion of pain assessment, pain medication dosages and side effects, and end-of-life decision-making. The lecture on the genetic evaluation of cancer focuses on topics such as assessment of risk for inherited cancer, identification of possible candidates for genetic testing, and the ethical and legal issues relating to genetic information confidentiality.

For more information or to request a speaker, call (800) 880-1300, ext 1671, or (512) 370-1671; or e-mail poep@texmed.org. ★

Baylor/Rice create dual degree program

A new health sciences management program produced by Baylor College of Medicine and Rice University, both in Houston, will offer two dual-degree programs — an MD/MBA and a PhD/MBA.

Students participating in the Baylor/Rice Program in Health Sciences Management will learn about health insurance, managed health care firms, pharmaceutical and medical supply companies, biotechnology companies, and other topics concerning health economics. For more information, call (713) 798-4842. ★

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BEFORE YOU SIGN

Contract TIPS

Things you need to know

Some managed care organization (MCO) contract questions defy categorization, but you'll want to know the answers to them just the same.

- **What is your marketing plan for this area?**
- **How many members do you currently cover in how many markets?**
- **What other doctors and hospitals in the area are participating in your program? What other providers in the area do you have plans to contact?**
- **What has been your financial success — profit or loss?**
- **What is the MCO's medical loss ratio?**
- **Will you provide me with an audited financial statement of your operation?**
- **Does the MCO "own" its own network or does it "rent" the network out to other insurance companies?**
- **What could lead to my termination from your network? What criteria are used to deselect a physician? What appeal process do you offer physicians in these situations?**

Source: TMA's Texas Physician Services Organization (TPSO). For more information about TPSO services or to request a copy of the TPSO catalog, call (800) 523-TPSO, or (512) 370-1418; or e-mail tpso@texmed.org.

New scholarships assist Harris County students

Medical students who attend school in Harris County can earn scholarships from a new fund. The Texas Medical Association Foundation Harris County Medical Society Auxiliary Scholarship Fund offers scholarships to third- and fourth-year medical students who are progressing satisfactorily with their school work and who are US citizens.

Scholarship recipients will be determined by the financial aid offices at Baylor College of Medicine and The University of Texas-Houston Medical School. This year, the two schools received $2,500 each to award to deserving students. The amounts presented to the schools vary in accordance with the annual interest earned by the fund, and the number of scholarships awarded is determined by the medical schools' financial aid offices. For more information, contact the financial aid offices at Baylor and UT-Houston. ★

Scientists give high ranking to UT Southwestern

When it comes to impact on fellow scientists, The University of Texas Southwestern Medical Center at Dallas ranks second among all American universities and medical centers cited in journal articles related to biology and biochemistry, according to a *ScienceWatch* survey.

The survey examines data from the Institute for Scientific Information, which publishes *Current Contents, Science Citation Index,* and *Journal Citation Reports,* and ranks the top 100 federally funded institutions for number of papers published in nine biological fields between 1993 and 1997. Relative impact was calculated using the average number of times a paper was cited in another paper relative to the world average for papers in the same field. Duke University ranked first in relative impact while Harvard University ranked third. ★

Mark Duga, DO, chief resident for anesthesiology at Baylor College of Medicine, left, and Cheryl Hammer, head nurse for anesthesiology, center, practice on the high-tech mannequin made from a sophisticated computer designed along the lines of a flight simulator. Baylor is the only medical school in Texas using the patient simulator.

Baylor residents learn from lifelike mannequin

Anesthesiology residents at Baylor College of Medicine in Houston are learning how to manage problems that might arise in surgery from a high-tech patient simulator set up in a fully equipped operating room.

"This simulator goes far beyond the typical CPR mannequin that most people have seen," said Hal Doerr, MD, director of the anesthesiology department's human patient simulator center. "It breathes, and has a heartbeat, pupils that react to light, a pulse that can be felt at four locations, and heart and lung sounds."

After spending their first 3 days in an intensive training session with the patient simulator, residents begin one-on-one training in hospitals with their anesthesiologist mentors. The simulator also is used to help advanced residents review lecture material, introduce medical students to drug interactions and clinical anesthesiology skills, and teach nurses crisis management. ★

MedWatch article offers vaccine safety education

A new MedWatch article titled "Post-marketing Surveillance for Adverse Events After Vaccination: The National Vaccine Adverse Event Reporting System (VAERS)" provides information on vaccine safety monitoring and is approved for a maximum of 1 free hour of AMA PRA Category 1 continuing medical education (CME) credit.

Health professionals, vaccine manufacturers, and the public voluntarily report clinical events after vaccinations to VAERS, the national passive surveillance system monitoring vaccine safety. The CME article, which is provided as a service by the National Institutes of Health/Foundation for Advanced Education in the Sciences and the US Food and Drug Administration (FDA), expires on October 31, 2001, and can be found on the MedWatch Web site at www.fda.gov/medwatch.

To obtain more information or to report serious adverse events involving vaccines to VAERS, call (800) 822-7967 or consult the FDA VAERS Web site at www.fda.gov/cber/vaers.html. ★

Presbyterian Hospital receives $500,000

Dallas' Cain Foundation donated a $500,000 endowment to the Institute for Exercise and Environmental Medicine (IEEM) at Presbyterian Hospital in Dallas to establish the Effie and Woffard Cain Chair in Cardiopulmonary Research. The IEEM, a cooperative effort with The University of Texas Southwestern Medical Center, provides research, education, and clinical practice aimed at improving human functional capacity in health and disease to maximize quality of life. ★

Help physicians in need during February fundraiser

This month, TMA's Physician Health and Rehabilitation (PHR) Assistance Fund asks you to "Have a Heart for Physicians." The PHR Assistance Fund provides financial assistance to physicians who cannot afford treatment for depression, chemical dependency, or other problems, or whose families need help with short-term living expenses while a physician receives treatment.

Physicians seeking assistance obtain a loan application from the PHR Assistance Fund, and a team composed of two PHR committee members and one TMA Alliance representative reviews the completed loan application. If the committee recommends approval of the loan, it makes that recommendation to the TMA Board of Trustees. After the PHR Assistance Fund receives approval of the loan, the applicant signs a loan agreement. When the PHR Assistance Fund receives the agreement, checks are forwarded to the appropriate person or entity. The first payment on a loan is due no later than 2 years from the date of the loan or 6 months after the physician becomes gainfully employed, whichever occurs first.

The PHR Assistance Fund relies on donations to continue this important work. To help your colleagues who are in recovery and need financial assistance, contact Linda Kuhn at (800) 880-1300, ext 1342, or (512) 370-1342; or e-mail linda_k@texmed.org. ★

TIPS ON HOW TO PUT YOUR PATIENTS FIRST

BEST Practices

Here are some recent words of wisdom on patient-physician communication from your colleagues.

"Treat your patients as you would wish to be treated."
– P.R. Gilmer, MD, Houston

"Remember why you went into medicine. Remember back in medical school — the interactions with patients that had the greatest impact on you. Look now at the moments in your busy life that truly give you real, heartfelt satisfaction. Look ahead to how you want to reflect upon your career in medicine. Then resolve to care. Resolve to fight when you should. Resolve to reflect upon what it is we do."
– Jeff Jekot, MD, Austin

Please send your suggestions for putting patients first and improving patient-physician communication to* Texas Medicine, *401 W 15th St, Austin, TX 78701; fax (512) 370-1632; or e-mail president@texmed.org.

Forum On Ethics

Handling coma and brain death

By Robert Fine, MD

Case study

After a lengthy debate with Mr Martinez,* three things were clear: one, he didn't want his wife to die; two, he wasn't about to agree to withdrawal of the ventilator; and three, he didn't understand much of what was being said.

Earlier in the day, his wife, a 68-year-old Hispanic woman, was brought to the emergency department with a massive intracerebral hemorrhage. Mr Martinez was called immediately. Meanwhile, after rapid and appropriate evaluation, she was declared brain dead. When he arrived, his wife's attending physician and neurologist explained her condition and the hospital's policy regarding brain death. They told Mr Martinez that when brain death was certified, the patient was declared legally dead and all life-sustaining systems were turned off.

"I don't want you to kill my wife!" he said. "You wait for my nephew. Don't kill her. I can see her heart beating."

**Names changed to protect privacy.*

Robert L. Fine, MD, is an internist and chair of the Institutional Ethics Committee at Baylor University Medical Center in Dallas. Reprinted with permission from Baylor University Medical Center.

Because Mr Martinez didn't speak or understand English well, it was difficult for the physician to explain brain death in a way he could comprehend. After 24 hours of discussion and debate, the ethics committee was called in and Mr Martinez's nephew, who was fluent in English, arrived to help.

"I'm really confused here," the nephew said. "One doctor said she is comatose; the other said she is dead. I don't believe it! I've heard about people who come out of this. A friend told me about her second cousin who was in a coma just like this and then woke up like nothing ever happened."

At first, the nephew stood firm that no life-support systems should be removed. After reexplaining the difference between coma and brain death, the ethics consultant and the family reached an agreement. Mrs Martinez would remain on life support for 2 days to allow the family to gather and come to terms with her death.

Discussion

Was this case handled appropriately? Ultimately, the answer is yes. The attending physician and consulting neurologist made reasonable attempts to explain the salient issues to the patient's distraught husband, although apparently some mixed messages were given about her condition. They were hampered both by his emotional state and by language barriers. However, even his nephew, who was unhindered by language barriers, was confused about the difference between coma and brain death. Taking the time to explain the difference between coma and brain death was the only way to reach an understanding.

When explaining these two conditions (and the related persistent vegetative state), it may be helpful to explain coma as a sleep state from which a person doesn't immediately awake. Patients with many forms of severe injury to the brain initially may present as comatose. Many of these injuries will be familiar to patients and their families, such as stroke, trauma, drug overdoses, etc. A patient may improve from a comatose state to some level of persistent brain injury or all the way to a complete recovery. The patient also may decline into a persistent vegetative state (often explained as an "eyes-open persistent coma" in which higher cortical function is lost but the brain stem is relatively intact), or they may decline to brain death. Brain death can be described as complete cessation of all brain activity including higher brain function and brain stem function. Patients may "wake up" from a coma but not from brain death. Note that family members often interpret the "eyes-open" aspects of the persistent vegetative state as an indi-

When explaining these two conditions, it may be helpful to explain coma as a sleep state from which a person doesn't immediately awake.

Texas Medicine welcomes comments about issues discussed in the Forum on Ethics. If you would like to comment or submit a column for possible publication, please contact Teri Moran, senior editor, at *Texas Medicine*, 401 W 15th St, Austin, TX 78701; phone (800) 880-1300, ext 1371, or (512) 370-1371; fax (512) 370-1632; or e-mail teri_m@texmed.org. Proposed columns must be no longer than 900 words and written in a case study format.

cation that their loved one is improving. Unfortunately, that is not really the case when all higher cortical function is lost. Although these concepts are clear to most physicians, the patient appears essentially identical in these states to the family and friends, making it hard for them to accept our technical explanations.

Families will understand these two states more fully after they have some time to absorb what has happened. Many times, a second or third explanation will be necessary. Drawing pictures or showing families MRI or CT pictures of the brain, both normal and injured, is often useful. Understanding a family's value system and educational background may help you as the physician to better explain things to them.

Coma, the persistent vegetative state, and brain death are three different conditions that, at the bedside, appear essentially identical to families and others. They are difficult concepts for families to understand. It is important for them to know the difference.

Try explaining that any serious brain injury initially presents as coma. From that point, patients ultimately will go in one of four general directions. Some will improve to some level of brain injury that leaves a loss of function, such as paralysis or inability to communicate. Some will return to normal. Some will enter a state of persistent, eyes-open unconsciousness, known as the persistent vegetative state. Some will deteriorate to whole brain death.

When patients are comatose, it may well be appropriate to provide many types of treatment and to discuss the benefits and risks of each offered therapy including cardiopulmonary resuscitation (CPR).

Patients who are declared brain dead are not sustained long term and are not offered CPR. All life-sustaining equipment is removed. It is confusing to family members to discuss with them whether they wish their loved one to have CPR, tube feedings, or other interventions if you have just told them that their loved one is brain dead.

There are only two reasons to sustain a patient who is brain dead — to preserve organs for transplantation and to allow the family time to make peace with the tragedy. Both justifications for the short-term support of brain dead patients are reasonable and should be encouraged. ★

Coma, the persistent vegetative state, and brain death are three different conditions that, at the bedside, appear essentially identical to families and others.

TB guidelines protect health care workers

The American College of Occupational and Environmental Medicine (ACOEM) has released comprehensive guidelines to protect health care workers from the resurgence of active pulmonary tuberculosis (TB).

ACOEM endorses the use of multiple steps to reduce the risk, including updated training of health care workers; optimal design, ventilation, and patient flow in clinical spaces; periodic TB testing of health care workers; effective respiratory protection; active infection control procedures; and periodic updating of written TB control plans.

"Employers are asked to perform two-step TB testing of all newly hired health care workers who have not had a TB test within the previous 12 months," said Lawrence W. Raymond, MD, member of the ACOEM Lung Disorders Committee that developed the guidelines. "Health care workers who could potentially care for or have airborne exposure from patients with active TB should have tuberculin testing every 3 to 12 months."

The ACOEM guidelines are based on those of the Center for Disease Control and Prevention, the National Institute for Occupational Safety and Health, and the Occupational Safety and Health Administration. For a copy of the guidelines, consult the ACOEM Web site at www.acoem.org or the ACOEM fax-on-demand service at (800) 226-3626. ★

Teens engage in risky behavior

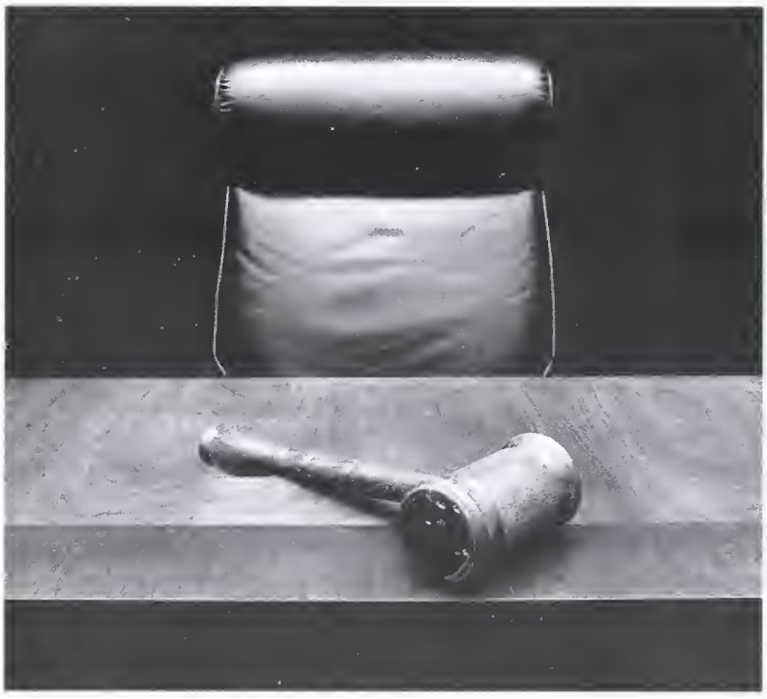
A special Centers for Disease Control and Prevention (CDC) survey authorized by Texas Education Commissioner Mike Moses in 1998 shows that Texas students engage in certain risky behaviors more than students in other states. The following Texas averages are higher than the national CDC averages for the behaviors indicated. Of the 2,863 Texas teens surveyed:

- 95% never or rarely wear a helmet while riding a bicycle;
- 51% had sexual intercourse;
- 48% rode in a car with someone who had been drinking alcohol during the 30 days before the study;
- Almost 47% reported at least one episode of binge drinking in the past 30 days;
- 34% drove a car after drinking alcohol in the 30 days before the survey, and 28% of them did it more than four times;
- 33% had participated in a physical fight in the past year;
- Almost 13% had tried cocaine;
- 12% carried a gun to school;
- 8% had attempted suicide at least once in the past year;
- 8% of females had been pregnant at least once; and
- 7% used laxatives or vomited to control weight.

The good news is, the rates for Texas teens are lower than the national CDC averages as far as not wearing seat belts and having sex without condoms. ★

Mining a new legal theory

Federal judge denies HMO's request to drop lawsuit



Ibid

A US district judge has created a new legal remedy for patients who believe their health plans have discriminated against them because of their disabilities. Best of all, Judge Fred Biery's ruling says the Employee Retirement Income Security Act (ERISA) does not protect health plans from such lawsuits. ERISA is a federal law that courts historically have allowed health plans to use as a shield against lawsuits for alleged negligent decisions. ➤➤

By Teri Moran, Senior editor

Because Judge Biery's decision is "reported," the case may be cited as precedent in future cases.

In *Zamora v HealthTexas,* filed in 1996, two Texas physicians and 13 patients sued HealthTexas, a San Antonio medical group, and five health organizations associated with it. The plaintiffs filed under the Americans with Disabilities Act (ADA) and the Rehabilitation Act, alleging that the organizations' system of financial incentives for physicians encouraged them to limit and deny care to reduce costs. They claim the organizations violated the ADA and Section 504 of the Rehabilitation Act when they allegedly discriminated against patients with disabilities and their physicians.

The defendants are HealthTexas Medical Group, Primary CareNet (which manages HealthTexas' administrative affairs), and four health maintenance organizations (HMOs) — Humana Health Plans of Texas, Humana Gold Plus, PacifiCare of Texas, and Secure Horizons. They have denied the plaintiffs' claim and are not commenting on the lawsuit or the judge's decision.

The judge's ruling, issued in December, clarified several points of law and set a precedent for future cases.

"Judge Biery's decision is a major development in the law holding HMOs accountable for their conduct," said Robert Provan, JD, the Austin attorney for the plaintiffs. Mr Provan filed the suit with the help of the Texas Medical Association and the American Medical Association/State Medical Society Litigation Center. "Now, for the first time, it is clear that the law prohibits them from discriminating against people with disabilities and the physicians who care for them," he said.

In his ruling, Judge Biery denied a motion for summary judgment sought by the defendants, and the case will go forward. He upheld several legal principles that are key to the plaintiffs' eventual success. They are:

- The physician-patient relationship plays a significant role in the delivery of health care in HMO plans.
- The ADA and the Rehabilitation Act apply to health care benefit plans and they protect patients with disabilities from discrimination by HMOs.
- HMOs such as Humana are "public accommodations" under the ADA because they effectively operate and control health care providers through their financial incentive plans.
- Financial controls HMOs place on provider groups may serve as the motivation for discrimination against patients with disabilities and their physicians.
- The patients in the case may seek an injunction to protect their rights under the ADA, as well as monetary damages under the Rehabilitation Act.
- The plaintiffs who are Medicare beneficiaries do not have to go through all the administrative review procedures available under the Medicare Act before filing suit under the ADA and the Rehabilitation Act.
- The Rehabilitation Act protects all HMO enrollees, both those in Medicare HMOs and those in traditional commercial HMOs.
- There is no safe harbor with the ADA or the Rehabilitation Act for Medicare HMOs.

Texas Medicine first reported the case in 1997. (See "Is Health Care Only for the Healthy?" June 1997 *Texas Medicine,* pp 27–31.)

Point, counterpoint

The first salvo in the case was fired in 1996, when HealthTexas filed a $1 million lawsuit against rheumatologist Jorge Zamora, MD, a physician the group had fired 3 days earlier. HealthTexas charged Dr Zamora with trying to solicit his old patients and with breaking his contractual covenant not to compete. The suit asked that he be restrained from contacting his former patients.

Dr Zamora denies the charges and says HealthTexas misconstrued his attempt to contact an ill patient about whom he was concerned.

Dr Zamora contacted TMA's General Counsel Donald P. Wilcox, JD, who referred him to a few attorneys and followed the case. The AMA/State Medical Society Litigation Center decided to use Dr Zamora's case to test the legal theory that deselecting physicians who treat chronically ill patients and, therefore, incur higher costs violates the ADA. Mr Wilcox brought the case to the attention of the litigation center and the TMA Board of Trustees. Both agreed to provide in-kind support to Dr Zamora.

"Judge Biery's decision is a major development in the law holding HMOs accountable for their conduct."

In response to the HealthTexas lawsuit against him, Dr Zamora, the former HealthTexas patients, and another former HealthTexas physician, internist Martin Guerrero, MD, filed a separate lawsuit against the defendants.

Drs Guerrero and Zamora allege they were forced to resign after working at HealthTexas for only 6 months. Both physicians allege they were ousted because they spent too much money treating their mostly chronically ill patients.

The defendants say Dr Zamora verbally resigned, then refused to sign a resignation letter, and then began to try to encourage HealthTexas employees and patients to contact his attorney.

The case has been in the discovery stage since 1996 and may not reach trial for another year.

Core complaints

The patient plaintiffs in the *Zamora* case all have disabilities or chronic diseases and allege they received abusive treatment by the defendants because of their disabilities. They claim they were ignored or mistreated while waiting for care in HealthTexas clinics and suffered denial or delay of medically necessary benefits, services, equipment, and treatments.

Legal articles in *Texas Medicine* are intended to help physicians understand the law by providing legal information on selected topics. These articles are published with the understanding that TMA is not engaged in providing legal advice. When dealing with specific legal matters, readers should seek assistance from their attorneys.

TexasMedical Association

As physicians, you know the greatest calling in life is to help those in need. The PHR Assistance Fund of Texas Medical Association does just that. The fund provides loans for medical and/or rehabilitative services to physicians experiencing depression, chemical dependency, and other conditions that impair their ability to lead productive lives. Funds may also be used for family living expenses.

Please help physicians who are in recovery and need financial assistance. We rely on donations to help us continue this important work. Send your Valentine donations to the PHR Assistance Fund at 401 West 15th Street, Austin, TX 78701-1680. Or call Linda Kuhn at TMA at (800) 880-1300, ext. 1342, or (512) 370-1342 for more information.

Have a Heart
FOR PHYSICIANS

A statewide fund-raising campaign for the Physician Health and Rehabilitation Assistance Fund

Joe Albert Garcia, who has quadriplegia, claims he was refused appropriate medically necessary equipment that resulted in severe ulcerations of his feet and ankles. He also alleges that he was required to appear personally at a HealthTexas clinic to retrieve prescription refills, rather than the clinic calling them in to the pharmacy. The clinic refused to return the pharmacist's phone calls, he says, and also denied him the means to appeal decisions regarding his medical care. The defendants deny the allegations.

Drs Zamora and Guerrero allege they were forced to resign in retaliation for upholding their professional and moral obligations to place patient care above profits. They claim they were forced to choose between less care to meet cost-containment goals and proper care of their patients. When they chose proper care of their patients, they say, they were forced to resign.

The defendants deny the charges, and in court documents, HealthTexas said it has never "participated in deselecting physicians because of their proper treatment of patients nor has it participated in any way in creating obstacles for treatment or in influencing patients to switch to other HMOs." The defendants claim that both internal and external reviews of their practices have confirmed that HealthTexas patients have received proper care. In court documents, the defendants have accused Dr Zamora, Mr Provan, Mr Wilcox, TMA, and AMA of defamation — intentionally and maliciously reporting false and disparaging information about them.

The bitter accusations between the parties continue to fly, and as both gear up for a court battle, no one knows for sure who will win. But with Judge Biery's decision, a precedent already has been established that cracks the legal defenses of health plans that traditionally have been shielded by ERISA, Mr Wilcox says. "From now on, patients with disabilities who believe their health plans are limiting or denying their care because it's expensive have considerable legal standing." ★

TexMed'99

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TEXMED '99 AT A GLANCE

EDNESDAY MAY 5

Sports Events
C. Lincoln Williston Golf Tournament

HURSDAY MAY 6

8-9:30 am
House of Delegates Opening Session

8 am-5 pm
Texas Academy of Family Physicians -- Add a Day to TMA

10 am-1:30 pm
Reference Committees

Scientific Sections
Digestive Diseases (9 am-noon)

Symposia
Emergency Medicine (9 am-1 pm)

2-5 pm
General Session

5-6 pm
Meet the Speakers Reception/Book Signing

After 6 pm
CMS Meet the Candidates Reception
Alumni Events
Alliance Dallas World Aquarium Dinner With Ross Perot
Nightlife Shuttle

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FRIDAY MAY 7

7:30 am-5:30 pm
Exhibits

9 am-noon; 1:30-4 pm
House of Delegates

9-10:30 am
Mercer Investment Seminar

8 am-5 pm
NEW! **Educational Tracks**
The Business Aspects of Medical Practice
Ethics EPEC End-of-Life Care (7:30 am-5:30 pm)
Technological Advances in Medicine

8 am-5 pm
Sections
Endocrinology (8 am-12:10 am)
Family Practice (9 am-5 pm)
Neurological Surgery
Obstetrics and Gynecology (2-5 pm)
Ophthalmology
Otolaryngology (9 am-5 pm)
Plastic, Reconstructive and Maxillofacial Surgery
Psychiatry (9 am-5 pm)
Public Health (8 am-4:15 pm)
Surgery

8 am-5 pm
Symposia
Blood and Tissue Usage (2-5 pm)
Diabetes (2-5 pm)
Sports Medicine

8 am-5 pm
Specialty Societies
Texas Dermatological Society (2-5 pm)
Texas Orthopaedic Association

noon-1:30 pm
TMA/TMAA Presidents' Installation Luncheon

2-3:30 pm
Mercer Investment Seminar

6-11 pm
TMA Foundation Benefit --New York Nights

After 6 pm
Alumni Events
Specialty Society Functions
Family Night Out Shuttle
Nightlife Shuttle

SATURDAY MAY 8

Sports Events
Tennis

7:30 am-4 pm
Exhibits

NEW! **8-9 am**
General Session

8:30 am-2 pm
Heard Natural Science Museum and Wildlife Sanctuary

9 am-4 pm
Culture Bus Tour

9 am-5 pm
NEW! **Educational Tracks**
The Clinical Practice of Medicine
Computers in Medicine
Ethics EPEC End-of-Life Care
The Science of Alternative/Complementary Practices (9 am-3 pm)
Socioeconomics

9 am-5 pm
Specialty Societies
Texas Dermatological Society (8:30 am-noon)
Texas Orthopaedic Association
Texas Society of Anesthesiologists

9 am-5 pm
Scientific Sections
Allergy, Asthma and Clinical Immunology (7 am-5 pm)
Colon and Rectal Surgery (9 am-12:30 pm)
Neurological Surgery
Ophthalmology
Otolaryngology (8:30 am-noon)
Pediatrics (9 am-12 pm)
Physical Medicine and Rehabilitation

9 am-5 pm
Symposia
Adolescent Risk Assessment (9 am-noon)
Cancer: What Primary Care Physicians Need to Know
Diabetes (9 am-noon)
Heart Care Partnership (9 am-1 pm)
Pain (9 am-noon)
Sleep Disorders (8 am-noon)

House of Delegates Sections
Organized Medical Staff
Medical Student
Resident Physician
Young Physician

After 6 pm
Alumni Events
Specialty Society Functions

SUNDAY MAY 9

EPEC Train-the-Trainer Workshop (8 am-noon)
Texas Dermatological Society (8:30 am-noon)

TexMed'99 Educational Showcase & Expo

REGISTRATION FORM

May 6-9, 1999 ▪ Wyndham Anatole Hotel, Dallas

One form per person. Duplicate as needed.

1 Complete registration form following steps 1 through 11 and return by fax or mail with payments.
Pick up tickets and badges at the registration area in the Atrium I lobby at the Wyndham Anatole.

Name _____ Member License # ❑ ❑ ❑ ❑ ❑

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Please check all applicable spaces below:

❑ TMA Delegate ❑ TMA Council Member Chair ❑ TMA Foundation Donor ❑ TEXPAC ❑ CMS Officer
❑ TMA Alternate Delegate ❑ TMA Committee Member Chair ❑ AMA Member ❑ TEXPAC 300 Club

2 Registration Fees

MEMBERS (Please check the applicable box)
❑ Physician FREE ❑ Medical Student FREE ❑ Intern, Resident, Fellow FREE ❑ TMA Member's Family *(attach names)* FREE

NONMEMBERS
❑ Physician @ $200 ❑ Intern, Resident, Fellow @$10 ❑ Medical Student @$10 ❑ Allied Health Personnel @$10
❑ Approved Visitor @$50 ❑ Nonmember's family over age 21 (attach names) @$10 ❑ Speaker (waived)

REGISTRATION SUBTOTAL $

3 Educational Tracks

Please indicate which of the following educational tracks you plan to attend:

NEW!
❑ The Business Aspects of Medical Practice (Friday)
❑ Technology Subtrack #1: Technological Advances in Medicine (Friday)
❑ Ethics EPEC End of Life Care (Friday and Saturday)
❑ The Clinical Practice of Medicine (Saturday)
❑ The Science of Alternative/Complementary Practices (Saturday)
❑ Socioeconomics (Saturday)
❑ Technology Subtrack #2: Computers in Medicine (Saturday)
❑ EPEC Train-the-Trainer Workshop (Sunday, 8 am-noon)

Please indicate which specialty program you plan to attend _____

4 Installation Luncheon $

Friday, May 7, noon-1:30 pm, Chantilly Ballroom West @ $15 per person x____ =

5 FAMILY ACTIVITIES $

❑ Dallas World Aquarium Dinner with Ross Perot (Thursday) @ $ 65 per person x____ = $____
❑ Concurrent Dallas World Aquarium Children's Activities @ $ 15 per child = ____
❑ Culture Bus Tour (Saturday)
❑ Heard Natural Science Museum and Wildlife Sanctuary (Saturday) @ $10 per person x____ = $____

6 ON-SITE CHILD CARE Child care will be offered at the Wyndham Anatole for Thurs.-Sun. daytime functions. $

Thurs.-Sat., 7:30 am-5:30 pm: Daily rates-Children 6 weeks to 3 years (not toilet trained) $39 per child; 3 years and up (toilet trained) $29 per child. Half-day rate for Sunday: Children 6 weeks to 3 years $29 per child; children 3 years and up $20 per child.

7 SPORTS EVENTS $

❑ C. Lincoln Williston TMA Golf Tournament (Wednesday) @ $125 per person x____ = $____
❑ Tennis (Saturday) @ $25 per person x____ = $____

8 New York Nights - TMA Foundation Benefit $

Friday, May 7, 6-11 pm, Wyndham Anatole Dallas Hotel
Option 1: Regular Tickets $100 per ticket x____ = Regular Ticket total $_____
Option 2: NYC Sponsor $125 per ticket x____ = NYC Sponsor total $ _____

9 Advance Copy of Final Program with presentation summaries and complete details (available early April) @ $10 $

10 Medical Student/Resident Sponsorships $

Help defray expenses for medical student/resident scientific poster displays by donation of $100, $50, or $25

11 TOTAL FEES (Steps 2-10) = $_____ ***(No refunds after April 15, 1999)***

❑ Enclosed is my check #_____ for $_____ payable to TMA. Charge to my ❑ Visa ❑ MasterCard ❑ AMEX Amount $_____

Acct. No. ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ Exp. Date ❑ ❑ ❑ ❑ ❑ ❑

Name on Card _____ Signature _____

Return form and payment information to TMA Conference and Meeting Management Department, 401 West 15th Street, Austin, TX 78701-1680, **fax (512) 370-1635**

❑ Check here if special assistance is required to fully participate. We will contact you to discuss your needs. We cannot assure the availability of disability assistance without prior notification of need. **Questions?** Call TMA Conference and Meeting Management Department, (800) 880-1300 or (512) 370-1300, ext. 1452 or 1453.

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Not the Feet of the One and Only (1993), left, was created by professional printmaker and UTMB Galveston psychiatrist Eric N. Avery, MD. *Not the Feet of the One and Only* shows Dr Avery's hands massaging the feet of one of his first patients at a time when many AIDS workers worried about exposure to the disease. The patient had Kaposi's sarcoma, a common AIDS-related skin cancer. (Jack S. Blanton Museum of Art, The University of Texas at Austin, The Elgin W. Ware, Jr./Texas Medical Association Collection, 1997)

The art of medicine

Physicians, patients draw knowledge, hope, and healing from the visual arts.

By Johanna Franke, Associate editor

Physicians examining art probably wonder how Monet's cataracts, Renoir's rheumatoid arthritis, and Van Gogh's mental illness affected their works, but the relationship between medicine and art goes much deeper. For physicians, art doesn't just hang on museum walls. It acts as a timeline of the medical profession, brings warmth into a technologically driven health care climate, and opens the door to better care by healing the body, mind, and spirit. ➤➤

Serious and satiric

One of French printmaker Jean Morin's most famous and rare etchings, *Memento Mori* (1640s), below, later was adapted as a funeral announcement and illustrates the transitory nature of life, a prominent theme in printmaking. "If I, personally, could own any one work in the collection, it would be the Morin because of my very traditional tastes," said Jonathan Bober, curator of prints and drawings at UT's Jack S. Blanton Museum of Art. *De que mal morira? (Of what will he die?)*, opposite page, is plate 40 from Francisco Goya's 1799 80-plate "Los Caprichos" series. One of the series' subthemes depicts human beings as donkeys — in this satirical work, the doctor is Goya's victim. The viewer is left wondering if the patient will die from an illness or a bad cure. (Jack S. Blanton Museum of Art, The University of Texas at Austin, The Elgin W. Ware, Jr./Texas Medical Association Collection, 1997)

Over the years, members of the medical profession have used paintings, prints, drawings, sculptures, and other forms of art to pass on knowledge about diseases and medical procedures to future generations, to make a statement about the society in which they lived, and to encourage patients to express their feelings about their ailments. The partnership between medicine and art has thrived over centuries, as evidenced by the number of masters who participated in dissections of the human body: Donatello, Vesalius, Fabricius, Michelangelo, Piero della Franchesca, Raphael, Botticelli, Dürer, and Leonardo da Vinci.

Medieval texts depicting trepannings, amputations, bladder-stone removals, and itinerant tooth-pullers eventually gave way during the Renaissance to Da Vinci's great depictions of the human body, such as *Studies of the Fetus* completed around 1510. Raphael presented the religious side of healing in 1517 with *The Transfiguration,* while Hans Holbein recorded history by painting the ceremony in which Henry VIII created the United Company of Barbers and Surgeons in 1540. Andreas Vesalius produced one of the greatest marriages of medicine and art with *De Humani Corporis Fabrica (Of the Structure of the Human Body)* in 1543. Stephen van Calcar, a student of Titian, illustrated this textbook of Vesalian dissections with drawings such as the *Muscle-Men* series.

From the first operation under ether to a dead-on depiction of gout, many artists represented medical progress and diseases with great respect and wonderment for the medical profession through the years. Perhaps this is why physicians often feel the same respect and wonder toward artists.

TMA joins the art world

Dallas urologist Elgin W. Ware, Jr, MD, enjoys great works of art, though he didn't realize how much until he received a proposal from Jonathan Bober, curator of prints and drawings at the Jack S. Blanton Museum of Art on The University of Texas at Austin campus.

After 10 years of service to the Texas Medical Association Board of Trustees, Dr Ware was appointed chair of TMA's History of Medicine Committee, which he described as a "good, tight committee of distinguished medical historians." The group looked for ways to bring a more prominent sense of culture back to the medical profession, which many patients perceive to have grown cold with its increased emphasis on technology and money.

"My feeling was that the general public was coming to regard organized medicine as just a political action committee interested in its self-serving bottom line," Dr Ware said, "whereas, in reality, it still maintains many aspects of the honored, learned profession that it has been through the ages."

In February 1993, Mr Bober offered the committee the perfect cultural collaboration — a chance to begin, in association with the UT Department of Fine Arts, a collection of prints and drawings depicting medical themes.

"I thought it would be a great opportunity for TMA to join in partnership with one of the preeminent land-grant universities in the country," Dr Ware said. "Furthermore, it would provide some evidence that doctors really were interested in the liberal arts and were not just money-grubbers."

Mr Bober's idea stemmed from the Ars Medica Collection, established 50 years ago at the Philadelphia Museum of Art with grants from then-SmithKline Beckman Corporation. Today, SmithKline Beecham still supports the acquisition of prints, drawings, and photographs with medical themes for Ars Medica.

Mr Bober knew prints would be the best medium to provide a pictorial timeline of medicine's past, as they represent a "visual language" that intertwines information with the aesthetics of the culture present during the artists' lives.

"Prints have always featured a conspicuous number of themes that come from outside the world of art, and those include a very rich history of medical imagery," Mr Bober said. "Medicine is something that is about both the scientific and the more humanistic; therefore, imagery often has been the most apt in capturing medicine's character or even its technical side."

Mr Bober had heard of TMA, and decided to seek its support. "I knew TMA to be powerful and reputable, so I thought, 'Why not?'"

After members of the TMA History of Medicine Committee embraced Mr Bober's idea, Dr Ware searched for 2 years with little success to find the funds for the new collection. Following Ars Medica's lead, he tried to garner the backing of several pharmaceutical companies as well as the TMA Board of Trustees, none of which had room in their budgets. Exasperated, Dr Ware decided to take a more personal interest in the collection in November 1995.

"I got to thinking, 'What the hell? I'll just fund it myself!'" he said. "I had a little extra money that year, so I decided to

"Prints have always featured a conspicuous number of themes that come from outside the world of art, and those include a very rich history of medical imagery."

Physicians at work

The Circumcision in the Stable (1654), below, a Rembrandt van Rijn etching, depicts the circumcision of Christ and was selected for the collection by Dallas urologist Elgin W. Ware, Jr, MD, in accordance with his specialty. "During this period, Rembrandt metaphorically represented the stages of human development through the life of Christ," said Jonathan Bober, curator of prints and drawings at UT's Jack S. Blanton Museum of Art. *Ward Rounds* (ca 1940), opposite page, is a Robert Riggs lithograph donated to the collection by Dr and Mrs John Minna, of Dallas. Though Mr Riggs was the leading photorealist lithographer during the early 1940s, he incorporated extreme light and overcharacterization of the subjects to make the work more surreal. (Jack S. Blanton Museum of Art, The University of Texas at Austin, The Elgin W. Ware, Jr./Texas Medical Association Collection, 1996 and 1997)

make it happen, and I've been able, thank goodness, to keep it rolling on an annual basis."

The first print obtained by The Elgin W. Ware, Jr./Texas Medical Association Collection of Prints and Drawings Devoted to Medical Themes was Jean Morin's *Memento Mori* (p 36), a rare etching dating back to the 1640s. Soon thereafter, Dr Ware helped select for the collection Rembrandt van Rijn's *The Circumcision in the Stable* (opposite page), which was completed in 1654. The collection, featuring the most celebrated names in the history of printmaking to a fair number of anonymous creations, now contains nearly 50 works and is growing.

Though he doesn't do much collecting himself, Dr Ware says he's enjoyed working with Mr Bober on the project. "This collection has turned out to be a very worthwhile thing, largely due to Jonathan Bober. Physicians should know that there's a whole other world out there in addition to what we do in clinical practice every day," Dr Ware said. When the collection "attains suitable proportion," he hopes to take it on the road to medical schools and large hospitals.

The collection will be on display as part of "The Human Condition" exhibition, June 18 through August 8, at the UT Art Building's temporary exhibition space on the second level. The UT Art Building is on the northeast corner of the intersection of San Jacinto Blvd and 23rd St across from Darrell K. Royal Texas Memorial Stadium. The exhibit will be supplemented with works of medical theme from the permanent collection of the Jack S. Blanton Museum of Art, formerly the Archer M. Huntington Art Gallery.

TMA members are welcome to view individual works in the collection by making an appointment with Rebekah Morin, curatorial assistant in UT's Department of Prints and Drawings, who can be reached at (512) 471-9208. Physicians who would like to contribute money or artwork to the collection should contact Mr Bober at (512) 471-7553. Artwork submitted must meet certain quality and subject matter criteria to be considered for the collection.

Portrait of an artist-physician

Another artist featured in The Elgin W. Ware, Jr./Texas Medical Association Collection happens to be a physician as well. Eric N. Avery, MD, an assistant professor of psychiatry and behavioral sciences and an associate member of the Institute for the Medical Humanities (IMH) at The University of Texas Medical Branch (UTMB) at Galveston, has been making relief prints since he was 13. At 50, Dr Avery seems to have lived several lives — all with the main goal of helping others, whether it be through art, medicine, or activism.

Dr Avery's father, a Harvard-trained pediatric hematologist who raised his family in Pecos, didn't encourage his son to follow in his footsteps, but rather those of Dr Avery's mother, an artist. The elder Dr Avery saw the talent that would make his son a professional artist one day, and the son made his way to the University of Arizona, where he earned a degree in art.

"I was doing art as my major, and it was so easy for me that it didn't seem like I was doing anything," Dr Avery said. The idea of studying medicine kept creeping back into his mind, and eventually a print teacher encouraged him to explore this interest.

After doing well in his science courses, Dr Avery was torn between pursuing medicine or continuing with art. The Vietnam War draft helped him with the decision. "My draft number was very low, and one of the ways you could stay out of the draft was by extending your education," Dr Avery said. "That was a very powerful reason I tried to get into medical school."

He was accepted into UTMB, which was undergoing a renaissance of its own as historian Chester R. Burns, MD, PhD, joined the staff. The IMH began incorporating disciplines such as art, history, ethics, philosophy, law, religion, and literature into UTMB's curriculum in 1973.

After graduating in 1974, Dr Avery kept up with IMH faculty members, with whom he had developed strong ties. He also completed a psychiatry internship at UTMB, finished a residency at the New York State Psychiatric Institute at Columbia-Presbyterian Medical Center in New York City, spent 3 months as an artist-in-residence with the humanities program at Pennsylvania State University's College of Medicine in Hershey, and then promptly returned to the art scene.

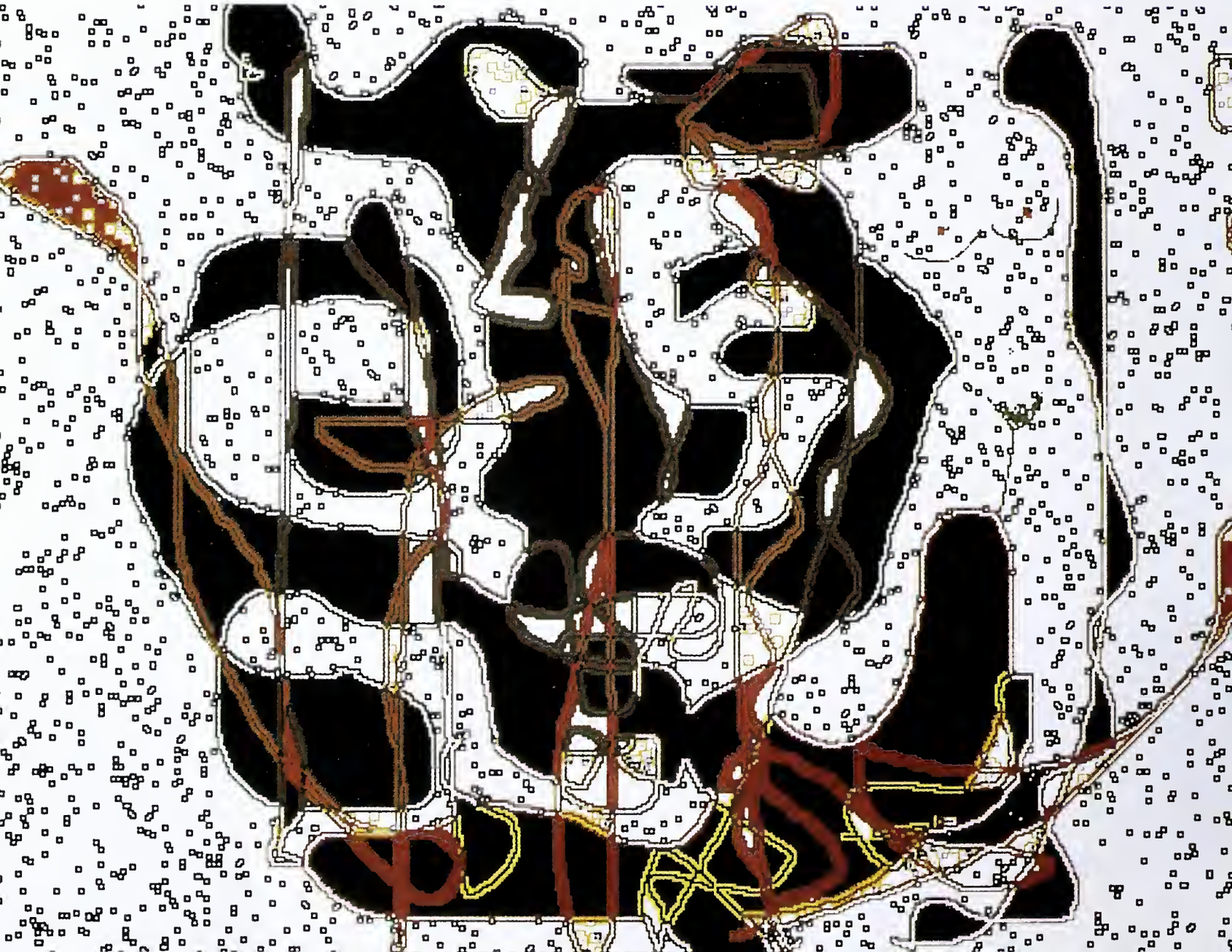
"I had continued developing my art skills all through medical school and my residency, and I had made this agreement with myself when I started medicine that I would stop at some point and return to my art making," Dr Avery said. "I took 2 years off and lived on New York's Lower East Side, played in a street band, and met, for the first time, artists who were a lot like me."

But Dr Avery couldn't stay away from medicine too long. He realized people suffering all over the world needed his skills. He spent 6 months in Northern Indonesia working with Vietnamese refugees caught up in the exodus brought on by the war and then traveled to Somalia to help famine victims for another 6 months. Dr Avery's volunteer experiences led him back to his art.

"Physicians should know that there's a whole other world out there in addition to what we do in clinical practice every day."

Works by artist-physicians

The 1991 four-color lithograph, *Schizolines*, below, was created by Nobel Prize-winning neurologist and former Baylor College of Medicine professor Roger Guillemin, MD, of Santa Fe, NM, who was inspired by electroencephalogram patterns. *The Last T Cell*, opposite page, a 1993 mandala-like metal plate relief print on monoprint background, was created by professional printmaker and UTMB Galveston psychiatrist Eric N. Avery, MD. *The Last T Cell* was made by Dr Avery during a stage of the AIDS epidemic when patients' T-cell counts kept dropping to the point where the remaining T cells would be given names. (Jack S. Blanton Museum of Art, The University of Texas at Austin, The Elgin W. Ware, Jr./Texas Medical Association Collection, 1997)



"People got terrible PTSD [post-traumatic stress disorder] from working in that disaster, and in order to help myself cope with that situation, I began making woodcuts with wood scavenged in the camp. I had a tent set up to use as a studio," he said. "At that point, the printmaking really began to help me keep myself together."

Upon his return from Somalia, Dr Avery quit medicine once again and moved to San Ygnacio, near Laredo, where he lived for the next 11 years and returned to full-time art making. He continued his volunteer work to help refugees from the civil wars in Central America who came across the Texas-Mexico border and immigrants from Mexico into the United States. Dr Avery helped organize Amnesty International USA's refugee work in Laredo and elsewhere in the country. His art, which began catching the eyes of museum curators across the nation, reflected the suffering of the refugees as well as people afflicted with a present-day plague.

"AIDS started killing all of my friends," Dr Avery said. "I had always said that if I practiced medicine again it would be to work with a real serious problem. That's pretty much all I've done is work in these traumatic situations."

During a fateful continuing medical education conference, Dr Avery ran into an HIV psychiatrist from UTMB, who encouraged him to return to his alma mater to develop the psychiatric services needed by AIDS patients. With support from his IMH friends, Dr Avery completed a fellowship in consultant-liaison psychiatry in 1994 and began caring for patients in UTMB's AIDS Clinical Care and Research Program. He is the director of HIV Psychiatry Services in the adult division of UTMB's Department of Psychiatry and Behavioral Sciences, and the primary HIV consultant-liaison psychiatrist for the AIDS Clinical Care and Research Program.

This time, he didn't give up his art for his medicine. The IMH offered Dr Avery an associate membership and a way to express both of his talents. "So 20% of my time, 1 day a week, I'm actually paid as a physician to stay in my studio and use my artwork to reflect my experiences with my patients," he said.

Like Dr Ware, Dr Avery has worked for years to bring the humanities into medicine. But some of his recent art takes the reverse approach. "I want to take medicine and move it into art space and ask questions like, 'What is the function of art?' and 'What are the functions of those art spaces? Are they places to preserve objects or are they places for learning and healing?'"

As a reaction to the changing health care environment, Dr Avery created "The Lost Art of Healing," an April 1997 exhibit that re-created a medical clinic in a University of Milwaukee-Wisconsin art gallery. In this clinical art action, a participating plastic surgeon consulted with consenting patients in front of the public as a performance artist peddled snake oil, diet pills, liposuction services, and surgical sex changes outside the examining room. Dr Avery's print art hung above the clinic and on the gallery walls.

"I wanted to take one-on-one work with a patient, which is under all of this pressure from managed care, and put that interaction in a protected space the way you do beautiful, endangered objects," Dr Avery said. "You put them in a museum to take care of them and keep them."

The Blanton Museum of Art at UT-Austin is home for about a dozen of Dr Avery's prints, including a 1980s AIDS suite as well as three 1993 works that are part of the Ware collection, *Blue Smallpox: The Print of Hope* (cover), *Not the Feet of the One and Only* (p 34), and *The Last T Cell* (below).

Dr Avery exhibited his latest project at Harvard University's Fogg Art Museum on World AIDS Day 1997. He designed an 8′ x 12′ room and papered it with wallpaper he created based on *Prison VII,* an 18th-century work by Giovanni Battista Piranesi. The paper depicted the life cycle of HIV by showing how HIV drugs work inside a lymphocyte. Health care professionals and consenting patients from Cambridge Hospital's AIDS facility, the Zinberg Clinic, moved into the art museum clinic for a 2-day art action.

"It was a regular HIV clinic," Dr Avery said. "Blood tests were drawn, physical examinations were performed, and social workers and nurse practitioners worked with the patients just like they did in the regular medical clinic. It was medicine as art and art as medicine."

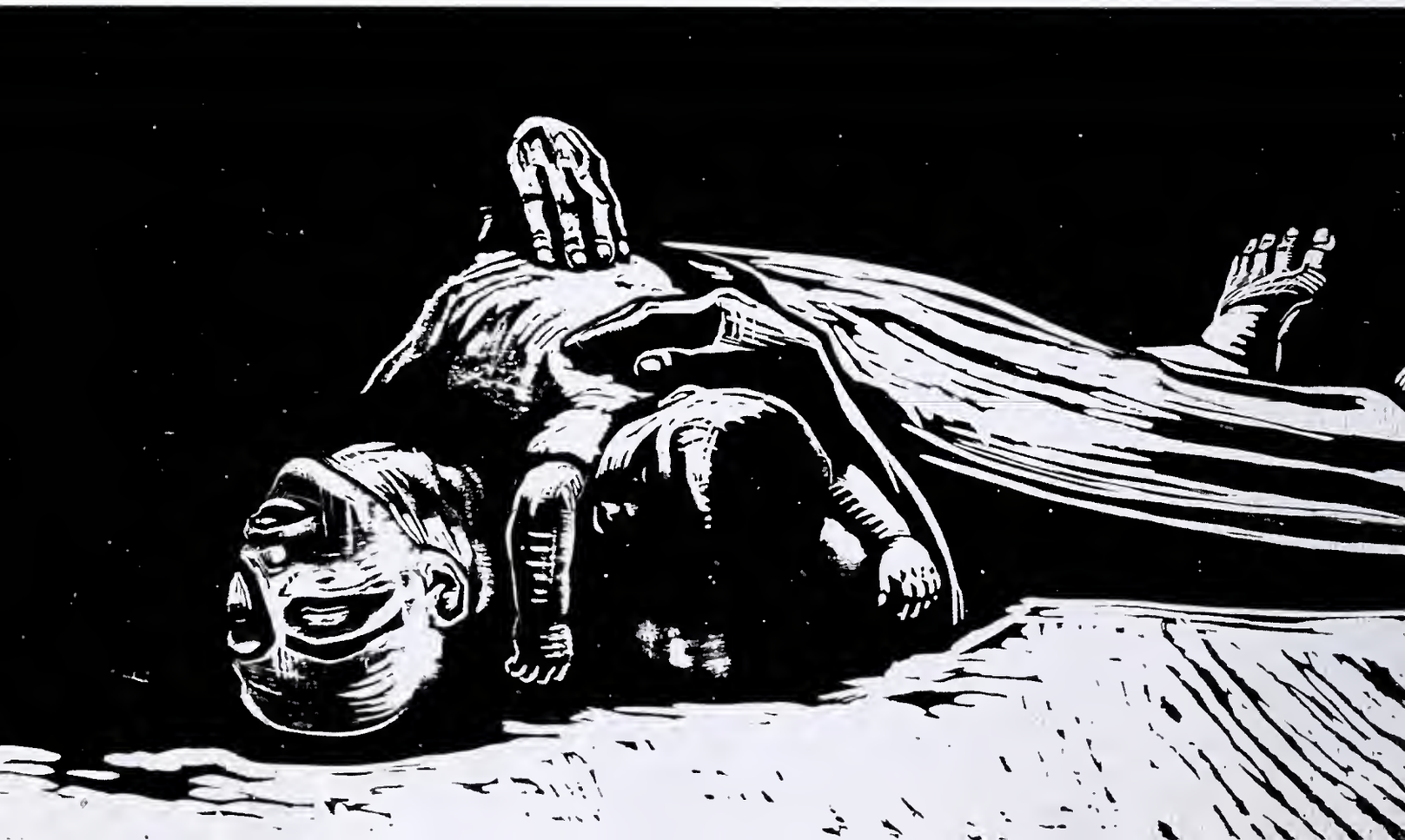
For the public, Dr Avery's art is "heightening sensitivity and the quality of life and increasing awareness of the world and the ability to respond flexibly and meaningfully to it," Mr Bober said. "Good art is about healing and improving the human condition."

For Dr Avery, his art provides him with the strength he needs to face another AIDS patient who may be on the verge of death. "Art helps me heal wounds and process my grief and trauma," he said. "But my recent clinical work in art spaces — in what's called the liminal space between art and medicine — is helping expand and define the relationship of the visual arts to the medical humanities. I hope it also helps remind my profession of something Hippocrates told us: 'Medicine is the most distinguished of all the arts.'"

"Art helps me heal wounds and process my grief and trauma. I hope it also helps remind my profession of something Hippocrates told us: 'Medicine is the most distinguished of all the arts.'"

A fortuitous find

Die Witwe II (The Widow II), below, is the fifth plate of Kathe Kollwitz's *Sieben Holzschnitte Zum Krieg (Seven Woodcuts on War)*, created in 1922 and 1923. The complete series, which was discovered in its original portfolio buried in the UT Fine Arts Library study materials, is worth "many tens of thousands of dollars," said Jonathan Bober, curator of prints and drawings at UT's Jack S. Blanton Museum of Art. Each plate depicts a different stage of suffering during World War I. (Jack S. Blanton Museum of Art, The University of Texas at Austin, The Elgin W. Ware, Jr./Texas Medical Association Collection, 1997)



Art and healing

It's no coincidence that art and medicine share the same patron saint — St Luke. Healing imagery runs through much of art from depictions of miraculous cures involving an assembly of saints to 18th-century anatomical diagrams to modern realist images created by artists such as Robert Riggs (p 39). But art can instigate healing as well as illustrate it.

Physicians and other health care professionals are finding that art can promote physical healing by allowing patients to work through their emotions. Creating works of art as well as participating in the more physical arts — music therapy, dance, Tai Chi, and yoga — has helped patients express their feelings and deal with the anger they have toward their illnesses. Often, patients learn something new about themselves that's reflected in their artwork.

"When patients look at their art, they get a picture of what's really going on with themselves," said Stephanie Woodruff, a professional art therapist in Houston. "The art takes and contains what's troublesome to patients and allows them to look at it at a certain pace and in a safe way."

This is especially true for children, says Donna Copeland, PhD, a clinical psychologist and chief of the behavioral medicine section of the Department of Pediatrics at The University of Texas M.D. Anderson Cancer Center in Houston. When a 7-year-old girl who had suffered from throat cancer and could not speak English visited Dr Copeland's department, the staff immediately gave her the materials to create a picture.

Dr Copeland described the drawing the child produced. "She drew a picture of a little girl with an arch on either side of her — kind of limiting her world in a way. She put in lots of blackbirds flying around her, which I think represents people talking in a language she doesn't understand, but she's safe within her arches. Underneath the little girl, she drew a choppy sea that represents her experience with throat cancer. She detached the little girl's head from her body, which shows the head-body disconnection she was feeling."

But the staff was encouraged when the child drew a smile on the head in her drawing. "When she left, she was smiling and happy," Dr Copeland said. "I think drawing a boundary around the little girl in the picture gave her a sense of security. She could never have been able to tell anybody those things, but she could express them in her pictures."

When children grow seriously ill, their artwork reflects their downturn, Dr Copeland says. "Their pictures fade in a way. These children use lighter colors, their marks are not as firm, and their work starts going toward the edges of the paper oftentimes."

But the survival rate of those who suffer from childhood cancers is 70% to 80%, so Dr Copeland and her staff use different types of art — from computer graphics to music to writing — to prepare kids to function in society as independent adults and cope with the trauma they experience during their illnesses.

M.D. Anderson's Children's Art Project, formerly known as the Christmas Card Project, has produced those internationally famous Christmas cards for 25 years from designs created by young cancer patients. In 1973, the project drew $550. In 1998, the project's creations, which have expanded to products like books and T-shirts, earned more than $1 million that paid for patient-focused programs, such as scholarships for former and current cancer patients, and staff artists, writers, and musicians.

"Pediatricians say what a positive force art is in the children's lives while they're undergoing treatment," said Tyrell Flawn, director of volunteer services at the Children's Art Project.

"It gives the children something to look forward to, to get up for."

Children aren't the only ones at M.D. Anderson visually expressing their concerns through art. The Children's Art Project recently developed a young adult/adolescent program, and the cancer center unveiled The Place ... of Wellness in October to help adults deal with cancer through both the visual and performing arts. Ms Woodruff, who lately has been working with women who have breast cancer, facilitates a healing art workshop for the program.

Ms Woodruff pinpoints the general area her clients are struggling with to prescribe art therapy. For instance, cancer patients often suffer from post-traumatic stress disorder, so she suggests the same activities that trauma victims participate in during their art therapy. She selects the proper medium, whether it is something soft like clay or hard like paper, and determines if her clients need paint or pencils to express their emotions and analyze them.

"A grocery sack is great for anger work because you can wrestle with something noisy and create a three-dimensional project out of it," Ms Woodruff said. "Clay work is used for soothing, comforting, and getting to the more positive side of things."

Art therapy's integration of mind, body, and spirit goes back to ancient religious healing ceremonies and, most recently, Jungian psychotherapy. As therapeutic art programs pop up across the country, more scientific evaluation of patient results, in addition to subjective measurements, will be conducted to prove the benefits of art in healing.

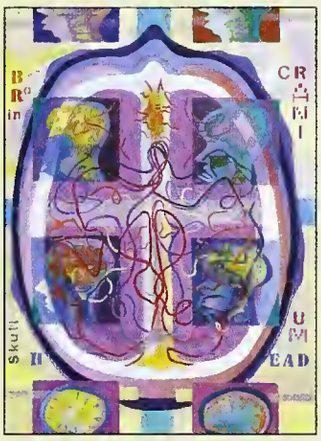
"We can even measure actual physical stress indicators such as lymphocyte counts," Ms Woodruff said. "The scientific literature's now there to support what we always knew intuitively about the healing aspects of art." ★

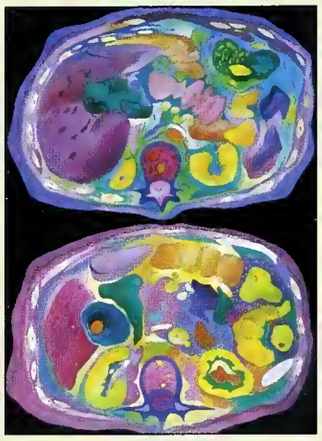
"The Human Condition"

An exhibition featuring The Elgin W. Ware, Jr./ Texas Medical Association Collection of Prints and Drawings Devoted to Medical Themes

June 18–August 8, 1999
Jack S. Blanton Museum of Art
The University of Texas Art Building
Northeast corner of San Jacinto Blvd and 23rd St

The human body as art





Wired (left) and *a la carte* (right), both created in 1997 and used as covers for the journal *Radiologic Technology*, are part of "The Fine Art of Healing" poster series of Med/ART paintings by donna krin Korkes. *Wired* was commissioned by 3M Medical Imaging. Ms Korkes' favorite painting, *a la carte*, so titled because it "looks like a dinner plate," is based on an abdomen x-ray, Ms Korkes said.

Some artists are inspired by trees, historical events, or a beautiful face. Artist donna krin Korkes is inspired by body parts on an x-ray.

A graduate of the University of the Arts in Philadelphia, Ms Korkes was painting Southwestern art that wasn't all that popular in New England when she looked deep inside, literally, for a new direction and began creating works from her own x-rays. "I realized the human body is a living work of art, and I could give that art a new visual perspective by adding beautiful colors and creating complex compositions," Ms Korkes said.

With some shrewd marketing, this new direction took off. In 1993, she opened Med/ART in Morristown, NJ. Soon she was creating commission work for 3M Medical Imaging, and designing the covers of *Radiologic Technology*, the bimonthly journal of the American Society of Radiologic Technologists. Physicians throughout the world have ordered Med/ART posters for their reception and examining rooms because of the originality, colors, and sophistication of Ms Korkes' oil paintings like *Wired* and *a la carte* (above).

"I've seen other art from x-rays, and nothing is quite the same as what I am creating," she said. "My anatomical artwork is friendly and doesn't show pain. People relate to the colors because bright colors, even in the worse situations, make people feel better."

For more information on Med/ART, call Ms Korkes at (973) 539-2179, or write to PO Box 853, Morristown, NJ 07963-0853.

Courtesy donna krin Korkes

An important reminder expressed through art

Victor J. Weiss, Jr, MD, left behind a representation of what he believed to be the real art of medicine — taking care of patients.

Though he's been gone for more than a year now, many Texas Medical Association members still miss Victor J. Weiss, Jr, MD. But they soon will be able to benefit from Dr Weiss' legacy, represented by a sculpture portraying the true meaning of being a physician, every time they walk through the front door of the TMA building.

Before he died in October 1997, Dr Weiss, a San Antonio psychiatrist and former member of the TMA Board of Trustees, committed the funds to create a sculpture for TMA's first-floor lobby foyer. He wanted the sculpture to depict the most important part of being a physician — caring for patients.

"He was devoted to the art and practice of medicine," said Belinda Weiss, Dr Weiss' widow. "He wished to impress upon those who enter the building of the Texas Medical Association that physicians and organized medicine continue to have a love and warmth for people little changed with the passing of time."

Coming from a long line of physicians — both his father and grandfather were doctors — Dr Weiss worried about patients' health and not their ability to pay bills, Ms Weiss says. "He treated everybody. If people did upholstery, they traded upholstery work. If they had bakeries, they brought him doughnuts. He practiced medicine that way, and you don't see that much any more."

After a long search, TMA's History of Medicine Committee found the perfect sculptor to communicate Dr Weiss' message to physicians in Garland A. Weeks, a native Texan from Marathon who has been sculpting for 30 years. By describing some of Dr Weiss' favorite works of art, such as Sir Luke Fildes' *The Doctor* (ca 1891), Ms Weiss was able to convey her husband's wishes to Mr Weeks, a former official state sculptor of Texas.

The 36-inch bronze sculpture will be mounted on a 36-inch wooden base and will be in the vein of "Norman Rockwell," Ms Weiss said. The sculpture is expected to be completed this spring.

Astragali: Healers in medicine, symbols in art
By Joseph M. Merrill, MD

(Editor's Note: Dr Merrill presented this paper as one of five lecturers at the opening of the 35th International Congress on the History of Medicine in September 1996 on the Greek island of Kos, Hippocrates' home. Others were delivered by delegates from the United Kingdom, France, Belgium, and Japan.)

To celebrate our debt to Greek medicine, I would like first to recognize ancient Greece not only as the source of today's medical ethics but also as the first to base medicine on rational science and organized teaching. These contributions not only initiated our subsequent achievements in medicine but in all forms of intellectual inquiry. Second, I would like to acknowledge Greek art as the origin and continuing core of Western aesthetics.

Greek medicine developed a talent for asking serious questions and answered them by applying the experimental method. When it was recognized that the human mind, when properly applied, could answer serious questions, the way was paved for medicine to advance. Meanwhile, Greek art pursued the classical ideal using purity of form and figurative plasticity to achieve beauty — achievements that have never been surpassed.

In this paper, I will link inscribed epigrammatic medical evidence with examples from Greek art. This method varies with the philosophy expressed by the Edelsteins, who first compiled the written testimonies of Aesculapius and published them in English (1). They purposely avoided archaeological evidence contained in coins, sculpture, and paintings because they felt that any interpretations we make about ancient Greek medicine should follow written evidence, but I intend to show meaningful relationships between the two.

Combining the written word with symbols also has another purpose: It points up some of the dilemmas of modern medicine. Using symbols, in a sense, is therapeutic in itself — for when we contemplate the concentration of high technology in our teaching hospitals, we need to reassure ourselves that our profession's humanitarian ideals, as laid down in the ethics of ancient Greece, will not just persist but will remain paramount in our professional work. I hope that this method of presentation will underscore yet another legacy of Greek civilization: the recognition that the aesthetic dimension of human experience is what delivers us from barbarism.

Astragali in art

An idealized Aesculapius shown in Fig I is a likeness acquired by the Copenhagen museum exactly 100 years ago, but nothing is known of its origin. Although Callistratus, working in the 2nd century BC was not speaking about this specific portrait, his words evoking the image of a universal healer describe it very well: "To me [this portrait is] not an image but truth. Stone though it is . . . [it] gives forth divine intelligence . . . the face flashes forth an indescribable depth of dignity mixed with compassion. . . . And although all things . . . are born to die . . . this head carries with it . . . indestructible youth."

Fig I. Sculpture of Aesculapius' face.

Astragali, the knucklebones of sheep or goats, were used in ancient Greece as dice for gambling and playing a game similar to jacks. Sophocles said these games were invented during the Trojan War to amuse the troops, and others have attributed their origin to Zeus himself. In the medical testimonials inscribed at Epidaurus, astragali figure prominently in two cures. In each example of Greek art that I have selected, be it sculpture, painting, or terra cotta, the artist has chosen astragali as the central motif.

Greek painting developed as an autonomous art form in the 5th century BC, but no originals from this Classical period have survived, which explains the importance of the 2000-year-old painting shown in Fig 2. This colored monochrome painted on marble and excavated at Herculaneum is now housed in the Naples Archeological Museum. These women (Leto, Niobe, Phoebe, Aglaia, and Hileaera) playing a game with astragali were painted by Alexander of Athens who was active in the 1st century BC.

Fig 2. Colored monochrome featuring Leto, Niobe, Phoebe, Aglaia, and Hileaera playing a game with astragali.

Because this monochrome is similar to reliefs dating from 430 BC, it is thought to be a copy of a painting dating from that time. Leto and Niobe have fallen out over a throw of astragali, and Phoebe tries to effect a reconciliation. Meanwhile, the other two women, impervious to their quarrel, are preoccupied with the outcome of their game. The dynamic equilibrium achieved by the artist with the massed figures has led modern critics to acclaim this a mature masterpiece (2).

The minor disagreement between Leto and Niobe is symbolic of a much greater quarrel between the two. Niobe, the first mortal woman violated by Zeus, was the mother of six boys and six girls. With Leto, Zeus fathered two Olympian deities, Apollo and Artemis. Leto, disparaged by Niobe for having only two children, sent

Astragali: Healers in medicine, symbols in art (cont.)

Apollo to kill Niobe's sons and Artemis to kill the daughters. Overcome by the loss of her children, Niobe fled to her father's house where Zeus, moved by her grief, turned her into a pillar of stone, which in summer still weeps. As early as the 560s BC, this Homeric legend was used to decorate Greek amphoras (3).

Now, what do knucklebones of sheep and goats have to do with medicine? At Epidaurus, two inscriptions from the 4th century BC associate astragali with curative powers. One inscription relates the story of a man with a paralyzed shrunken hand who, though doubtful of a cure, practices the prescribed ritual and at the very moment he attempts to throw an astragalus, is cured by Aesculapius. Translated, the text reads as follows: "A man whose fingers were paralyzed came as a suppliant to the god . . . in his sleep he saw a vision. It seemed to him that, as he was playing at astragali and was about to throw them, the god appeared, sprang upon his hand, and stretched out the patient's fingers. When the god had stepped aside, it seemed that he could stretch out all his fingers one by one. . . . When day dawned he walked out sound."

At Epidaurus Testimony 8 reads: "Euphanes, a boy of Epidaurus . . . suffering from stone, slept in the temple. It seemed to him that the god stood by him and asked: 'What will you give me if I cure you?' 'Ten astragali,' he answered. The god laughed and said to him that he would cure him. When day came he walked out sound."

Fig 3. Sculpture from the Captoline Museum in Rome.

The popularity of astragali players as a subject for sculptors is indicated by excellent examples housed in the museums of Crete, Berlin, and Budapest. The sculpture shown in Fig 3 is from the Captoline Museum in Rome. Pliny the Elder praised Polycleitus' *Two Boys Playing With Astragali* that stood in the forecourt of the palace of the Emperor Titus as "the most perfect work of art in existence." Ironically, the eruption of Vesuvius in 79 AD that preserved the Herculaneum painting for us killed Pliny the Elder when he sailed too close to get a better view.

Terra cotta was another art form often used to show astragali players. The earliest Greek terra cottas found at Knossos date from 5000 to 3000 BC, but the oldest we have featuring an astragali player dates from the 4th century BC. Fig 4 shows how an artist used astragali players to feature Hellenistic naturalism. A recent show at Venice's Palazzo Grassi, "Greeks in the Occident," featured two women dressed in chitons who are absorbed in their game. The style of their faces is said to suggest that it was made about 330 BC. By exhibiting the female figure in a number of poses, artists concealed and revealed the human figure very effectively. These minor masterpieces, breathing the life of yesterday, span our past with our present.

Fig 4. Astragali players featuring Hellenistic naturalism.

Links to today

Aesculapius was created by Greek minds as the god of universal healing. How can the astragali cures be explained within a framework of rational medicine? Apparently, the physicians of ancient Greece understood better than we that many natural phenomena occur that defy explanation. Therefore, patients who could not be cured by human knowledge might be cured by the advice Aesculapius gave during their dreams in the temple — not unlike the cures patients nowadays find with "alternative medicine."

Ancient Greece created two kinds of medicine: first, the Asclepian or religious medicine and, second, the Hippocratic or rational medicine. But, as has been pointed out, these two are not necessarily antagonistic (4). When rational medicine fails, physicians who respect medicine as a profession that is dedicated to healing have no difficulty in accepting cures that alternative medicine sometimes affords.

Lastly, the glorious ideals generated by the art of healing and the symbolism the Greeks expressed in their art can serve as an inspiration for our youth. If we as physicians are uncompromising in supporting medicine's ideals and stick with them, then there is no way that our students can fail in their pursuit of truth in medicine.

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Dr Merrill is a professor in the Department of Family and Community Medicine at Baylor College of Medicine in Houston.

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Antitrust hammer

Insurers threaten physicians who resist unfavorable contract provisions

Regan Dunnick

When the physicians of Genesis Physicians Practice Association (GPPA) in Dallas received a letter from Aetna US Healthcare in November threatening legal action for antitrust violations, they were taken aback.

"We, of course, were angered and a little bit surprised," said Stan Pomarantz, MD, vice president for medical affairs of System Health Providers (SHP), the management company for GPPA. ➤➤

By Ken Ortolon, Associate editor

GPPA and some 560 of its member physicians for months had been locked in a dispute with Aetna over what the physicians viewed as Aetna's failure to comply with their contracts and provide information that was critical to the physicians' management of patient care. When GPPA decided to terminate its contract with Aetna's health maintenance organization (HMO), that's when the antitrust threat arrived. Aetna, the November 4 letter claimed, was unable to recontract directly with the GPPA physicians because GPPA was "improperly and illegally interfering."

"We viewed it as an act of desperation by Aetna to try to quiet us because it had not made the inroads that it thought it should be making," Dr Pomarantz said. "Aetna failed to understand that our physicians weren't signing [new contracts] because our physicians were upset with them. Aetna thought it was because of actions that we were taking."

Dr Pomarantz believes GPPA was on solid legal footing in the actions it took in its negotiations with Aetna. But Aetna's attempt to use the threat of antitrust action against physician groups is not an isolated incident. In fact, it is being used with regularity by managed care entities across the country. And, it frequently is having a chilling effect on the attempts of physicians to stand up against managed care contract provisions that are unfavorable to both physicians and their patients.

The irony of a huge, multibillion-dollar company such as Aetna — itself exempt from antitrust laws — threatening individual physicians with legal action has not been lost on lawmakers. And there likely will be attempts next year in both Congress and the Texas Legislature to level the playing field for physicians.

Modus operandi

"It does appear that it [the antitrust threat] is becoming a standard modus operandi for managed care entities that are contracting with physician networks that have substantial clout based upon their popularity in the community or their sophistication," said Texas Medical Association lobbyist Connie Barron. "If the physicians attempt to negotiate too strongly and they hang together as a negotiating body, then the HMO threatens them with an antitrust action."

Kim Ross, TMA vice president for public policy, says the very idea that a multibillion-dollar giant such as Aetna could be bullied or prevented from carrying out its business by a few hundred physicians "is absurd on its face."

However, the threat of antitrust action is a powerful weapon for the HMOs in their efforts to force physicians to accept unfavorable contract provisions — a weapon that Mr Ross says carries the full force of the federal government behind it.

"We viewed it as an act of desperation by Aetna to try to quiet us because it had not made the inroads that it thought it should be making."

Under federal antitrust laws, physicians are not allowed to band together to discuss contract provisions or fees. If physicians violate that prohibition, the Federal Trade Commission (FTC) and the state attorney general can bring civil penalties against them and order them to pay restitution to the HMO. Also, physicians can be fined $10,000 per violation and ordered to pay the costs of prosecuting the case.

"Effectively, the HMOs are utilizing the FTC and the attorney general to break up these physician groups that are organizing to advocate for better delivery of medicine, better patient care, and protection of the physician in the market," said Austin attorney David Hilgers, JD, who represents an Austin physician group that is under investigation for antitrust violation.

Mr Hilgers says the Austin independent practice association (IPA), Texas Surgeons PA, tried to use a "messenger model" to negotiate fees with HMO Blue, the health maintenance organization of Blue Cross Blue Shield of Texas. HMO Blue refused.

Under the messenger model, physicians in a network appoint a third party as their messenger. The messenger communicates with each physician in the network individually to determine what fee range the physician will accept. The messenger then aggregates the information, presents it to payers, and solicits offers. The physicians never discuss the fee ranges among themselves.

If a payer makes an offer, the messenger must relay it to each physician and obtain the physician's individual decision about whether to accept the offer. The messenger may not inform physicians about the decisions of other physicians in the network or influence any physician's decision.

When all of Texas Surgeons physicians independently decided to terminate their HMO Blue contracts, Blue Cross eventually agreed to the messenger model, but also asked the FTC and Texas Attorney General's Office to investigate Texas Surgeons. The FTC has proposed fines against Texas Surgeons.

"What you have is an unbalanced market, a market that doesn't make sense because you have the HMOs with huge shares of the patients and a doctor with only an infinitesimal portion of the market," Mr Hilgers said. "The FTC ignores the fact that the HMOs have all the market leverage against these individual doctors. It says the size of the HMOs doesn't matter, that the doctors should not organize and effectively negotiate with the HMOs on a unified basis."

David versus Goliath

Ironically, it's the HMOs who make themselves out to be the party being bullied in these cases. In an opinion article that appeared in the *Dallas Morning News* in November, Dallas County Medical Society President Robert T. Gunby, Jr, MD, said Aetna

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had staked out the "David position" in its battle with GPPA. "It becomes rather ridiculous when a $19 billion, multinational corporate Goliath cries for the government's protection in a battle against an obviously overmatched opponent," Dr Gunby wrote.

While GPPA believes it has more protection from antitrust action because it is a financially integrated entity rather than a network of individual physicians, Dr Pomarantz says the antitrust threat did have an impact on the group.

"I think it is worrisome that Aetna seems to think it is permissible for it to abuse physicians without any threat of antitrust violation to itself," Dr Pomarantz said.

The fact that Aetna and other insurers face no antitrust threat is the "dirty little secret" in the whole issue, Dr Gunby said in his article. Insurance companies have been exempt from federal antitrust laws for decades because of the fact that the various companies share risk through reinsurance and other mechanisms. That makes it necessary for them to share data in order to assess their own risk in the insurance marketplace.

Mr Ross says that is not an indefensible exception to the antitrust laws. "But the fact that they have it and physicians don't in the kinds of bitter negotiations that are going on means they can bully physicians with antitrust allegations that would swamp any major physician group," he said.

Merging of giants

The recently announced merger of Aetna with Prudential HealthCare has compounded concerns physicians have about the HMO's antitrust tactics as Aetna attempts to become even larger and gain more market dominance. In a December 18 letter to the Antitrust Division of the US Department of Justice, American Medical Association Executive Vice President E. Ratcliffe Anderson, Jr, MD, asked the Justice Department to review the proposed merger carefully and challenge its anticompetitive aspects.

"By increasing its market power, Aetna also will continue to drive medical decisions based on financial and stockholder expectations," Dr Anderson wrote in his letter. "This threat is not theoretical. For example, Aetna has used its current market position to impose unreasonable contract provisions on physicians that define medical necessary services as 'the least costly of alternative supplies or levels of service.' Any increase in Aetna's market power would further diminish the ability of patients to receive the quality of care they seek from physicians devoted solely to their best interests."

"We plan to reintroduce the bill in February so that we can continue consideration," Mr Khan said. Representative Campbell plans a big push for both Republican and Democratic cosponsors so the measure will have broad-based, bipartisan support.

"The prospects obviously are still up in the air, but we feel pretty good," Mr Khan said. "We're getting calls from all over the country, and members from both sides of the aisle are interested in supporting it."

"If this merger goes unchallenged, it would create a piece of the rock large enough to flatten the health care systems of Dallas, Houston, and the rest of the Lone Star State."

TMA joined AMA in seeking Justice Department review of the merger. "It's been difficult enough for Texas physicians and their patients to endure the bottom-line motivations of Aetna US Healthcare," Bohn D. Allen, MD, chair of TMA's Council on Socioeconomics, said in a statement released December 18. "If this merger goes unchallenged, it would create a piece of the rock large enough to flatten the health care systems of Dallas, Houston, and the rest of the Lone Star State."

Leveling the playing field

While the Aetna-Prudential merger was raising new concerns about HMO dominance, at least one congressman was attempting to take the antitrust hammer away from the managed care entities. In July 1998, US Rep Tom Campbell (R-Calif) introduced legislation that would allow physicians to collectively bargain contracts with HMOs. A hearing on the bill, the Quality Health-Care Coalition Act, was heard in the House Judiciary Committee shortly after it was filed, but Suhail Khan, press secretary for Representative Campbell, says the bill got lost in the shuffle after the committee received Independent Counsel Kenneth Starr's report on the allegations against President Clinton.

Mr Khan adds that a broad coalition of health care groups also has endorsed the bill, including AMA, the National Community Pharmacists Association, and several mental health groups.

At the time he filed the bill, Congressman Campbell said medical professionals should be allowed to form associations and bargain with HMOs rather than have the federal government set out rules that favor the HMOs.

"In allowing health care professionals, including physicians, nurses, pharmacists, and midwives, to form their own professional associations and bargain with the HMOs and other organizations in their areas, all health care professionals will be enabled to secure contracts of a more fair and equitable nature, and the patients will be better served," he said.

Meanwhile, Mr Hilgers says legislation also should be considered at the state level to limit the attorney general's ability to assist the FTC in antitrust investigations.

"Both the state of Texas and the federal government have enforcement ability here," he said. "We may not be able to do anything about the federal government, but here in Austin we can certainly act to ensure that our attorney general is not being used unfairly by the HMOs to feather their own nests." ★

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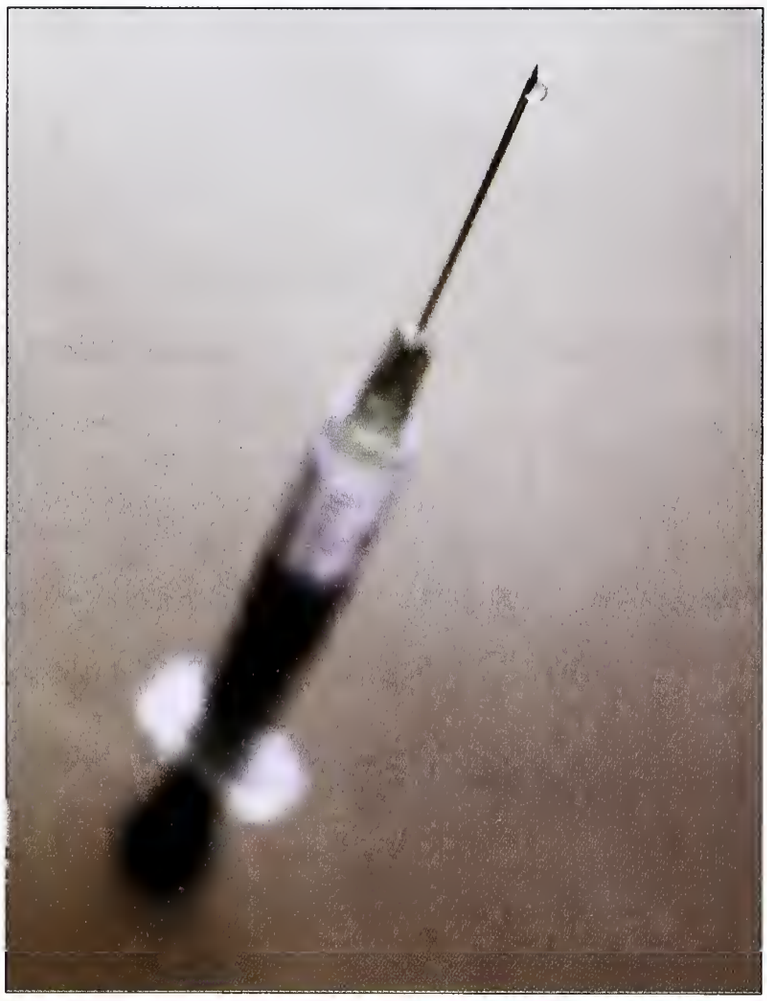
TexasMedical Association

Swapping for life

TMA supports needle exchange programs



We count them among civilization's dregs and enthusiastically fund government efforts to keep them off the streets and in prison whenever possible. But since the onset of AIDS, their economic toll on society has escalated, reaching an estimated $58 billion a year. Intravenous drug users in the United States number 1.1 to 1.5 million. Studies show that of the estimated 41,000 new HIV infections in the country every year, about 75% are among intravenous drug users, their sexual partners, and their offspring.

By Teri Moran, Senior editor

Needle exchange programs (NEPs), which enable drug users to exchange used needles for sterilized ones, have existed in the United States since 1986. Most of them are part of larger rehabilitation or harm reduction programs.

NEPs are technically illegal in most states, although some states make exceptions. A recent count showed that 47 states and Washington, DC, have drug paraphernalia laws that limit the possession of and/or distribution of syringes. A 1996 survey showed that in states with drug paraphernalia laws, 27 exchange programs were state-authorized and 13 were legal, based on local interpretations of state law or public health emergency powers.

Although Texas has the fourth largest number of AIDS cases in the country, needle exchange programs are illegal in the state. The only ones that exist are underground.

With a House of Delegates vote last November, the Texas Medical Association joined many other medical organizations, including the American Medical Association, in supporting NEPs (see "TMA delegates vote in favor of needle exchange").

Harm reduction

The harm reduction philosophy behind NEPs recognizes that addiction has increased in the past 20 years despite current policies. Needle exchange advocates say addicts will get intravenous drugs and needles regardless of the law, that NEPs do not increase drug use, and that the programs reduce the spread of infectious diseases, including HIV. Six major US studies unanimously support this position. To see studies on the programs, go to the AMA Web site at www.ama-assn.org, select "Search," and type "needle exchange." The site includes a comprehensive review of published research performed by the University of California that includes these oft-cited studies:

- A 1994 study of a New York City needle exchange program found that the rate of new HIV infections for participants in the program was 2%, much lower than the estimated 4% to 7% HIV infection rate among drug users not enrolled in the exchange program (1).
- A 1992 New Haven, Conn, study tested needles returned for exchange and developed a mathematical model that estimated a possible 33% reduction in the rate of new HIV infections among NEP clients (2).
- A worldwide study found that the HIV infection rate among drug users fell an average of 6% per year in the 29 cities with needle exchange programs and rose by 6% a year in 51 cities without the programs (3).

The list of luminaries and institutions that support needle exchange programs is long and includes the National Institutes of Health (NIH) Consensus Panel; NIH Director Harold Varmus, MD; the American Public Health Association; and US Surgeon General David Satcher, MD.

Richard A. Evans, MD, of Houston, is director and past president of the Drug Policy Forum of Texas, a group dedicated to the open discussion of alternative drug policies based on public health. Dr Evans says he supports NEPs because they save lives. "The evidence abounds that needle exchange programs prevent people from contracting infectious diseases. And, it's much cheaper and more humane for society to spend pennies on clean syringes than thousands treating AIDS patients."

But not everyone agrees that they are effective or appropriate. Janet Lapey, MD, immediate past president of the antidrug group, Drug Watch International (Web site www.DrugWatch.org), has said that studies of the programs are flawed and inconclusive. "The truth is that needle exchange programs take credit for success that actually is due to other components of the programs. Traditional outreach programs have provided AIDS and drug education, counseling, condoms, bleach, instruc-

"The evidence abounds that needle exchange programs prevent people from contracting infectious diseases. And, it's much cheaper and more humane for society to spend pennies on clean syringes than thousands treating AIDS patients."

TMA delegates vote in favor of needle exchange

The Texas Medical Association's House of Delegates voted last November to approve the following four recommendations submitted by the Reference Committee on Public Health:

1. **That the Texas Medical Association educate its members on the scientific studies relating to needle exchange programs.**
2. **That the Texas Medical Association agree that any harm reduction strategy among intravenous drug users should include a recommendation to cease drug use and the provision of effective treatment. If cessation cannot be achieved, education about the value of clean needles and syringes and information about needle exchange can be useful.**
3. **That the Texas Medical Association encourage the application of needle and syringe exchange and distribution programs at the community level.**
4. **That the Texas Medical Association, through the Council on Legislation, support legislation for needle exchange programs.**

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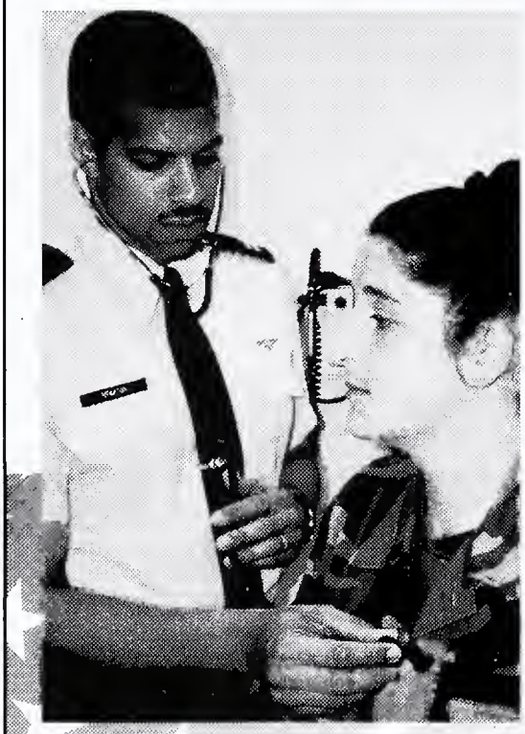

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tions regarding sterilization, access to treatment, HIV testing, screening for sexually transmitted diseases, and tuberculosis testing, etc. Needle distribution has been tacked onto these programs. Therefore, to fully evaluate the needle component, one must compare needle exchange programs to programs that provide the other very important components, minus the needles."

Last April, US Secretary of Health and Human Services Donna Shalala proposed lifting the ban on federal funding of NEPs that has existed since the late 1980s. The ban prohibited the use of federal funds for the programs unless it can be shown that they do not increase drug use and that they do reduce transmission of the AIDS virus.

However, the political firestorm her proposal created in Washington caused the Clinton administration to back down. The House of Representatives immediately passed a bill last April to permanently ban federal funding of NEPs.

A Harris survey of 1,003 American adults last year showed 71% believe cities and states — not the federal government — should decide whether federal HIV prevention funds could be spent on NEPs. Even many respondents (69%) who don't support the programs believed cities and states should be able to choose how to spend federal HIV prevention funds.

House Majority Whip Tom DeLay (R-Tex) voiced the opinion of many critics when he told the Associated Press that condoning the concept of giving free needles to drug addicts raises the white flag of surrender in the drug war. "The Clinton administration's endorsement of needle exchange programs is part of an intolerable message to our nation's children sent by the White House that drug use is a way of life," he said.

Dr Evans disagrees with this sentiment, saying that Representative DeLay underestimates the ability of children and their parents to understand this enigma. "We are trying to save lives — to prevent the spread of AIDS to innocent victims such as the sexual partners or children of drug abusers. Current policy excludes the

medical community from this vital public health arena."

Left to the states

Bills that would make an exception to drug paraphernalia laws to allow for needle exchange programs have never lasted long in the Texas Legislature. But Texas has some of the largest US cities, where intravenous drug use thrives, and program advocates say it's time Texas joined states like New York and California in implementing legal programs. "If studies show needle exchange programs can cut the spread of HIV by a third among intravenous drug users, why aren't we jumping at the chance to take this preventive measure?" Dr Evans said. "Addicts usually stop voluntarily within 8 years and return to society with no external indication of previous addiction. Needle exchange programs protect their health and encourage their recovery." ★

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After *Hopwood*

New programs seek diversity in medical school enrollment

Ibid

When the *Hopwood v Texas* decision was issued in 1996, the state's publicly supported medical schools began scrambling to comply with the court ruling while maintaining an ethnically diverse student body. They were motivated by dual concerns of providing opportunities for qualified minorities and making sure the Texas minority population received the health care it needs. ➤➤

By Cynthia S. Myers

According to figures compiled by the Texas Medical Association, while African Americans and Hispanics make up 13% and 26%, respectively, of Texans, only 3% of Texas physicians are African American and only 9% are Hispanic. Issues of balance and fairness aside, this means that when African Americans or Hispanics go to see a doctor, they are less likely to find someone who shares the same cultural background. Or they may have to travel some distance from their neighborhoods to find a doctor at all. A *New England Journal of Medicine* article (1996;334:1305-1310) reported that predominately Hispanic or African American communities were four times more likely to experience physician shortages.

As a result, minority populations were less likely to seek medical care. When African American and Hispanic patients did visit a doctor, they were most likely to follow the physician's recommendations if the physician was of the same ethnic background.

Texas medical schools have long struggled with the challenge of ensuring an ethnically diverse mix of doctors to serve Texas' ethnically diverse population by using legally acceptable affirmative action. The *Hopwood* ruling, in which the Fifth Circuit Court of Appeals held that race could not be considered as a factor in admission to public professional schools, made this task even more difficult.

Texas medical schools have initiated new efforts to increase diversity in medical school enrollment. TMA supports these efforts and has created a minority scholarship fund to expand opportunities for underrepresented minorities.

Widening the field

Following the *Hopwood* decision, Texas medical school enrollment fell 38% for African Americans and 22% for Hispanics in the fall of 1997. "We recognized that we had to find a way to ensure our classes were representative of the citizens of Texas," said James Guckian, MD, vice chancellor for health affairs of The University of Texas System. "We worked hard to devise a set of criteria that continued to address the needs of Texas but were race-neutral."

The new criteria expand the ranges of grade point averages and minimum Medical College Admissions Test (MCAT) scores for students considered for interviews at UT medical schools. The criteria also take into account such factors as the student's family background, hometown, ability to speak a second language, involvement in college extracurricular activities, and the student's own vision for his or her future as a doctor. This allows for a larger pool of applicants from which to draw for the face-to-face interviews.

Such interviews always have been a part of the medical school application process. "We did interview a larger number of students," Dr Guckian said. "We felt like there was some criteria we really needed to evaluate. One of the best ways to evaluate students is face to face, in terms of what they were like, how they felt about the world, where they were going to practice, things that you could obtain only through an interview."

Under the expanded application criteria, medical school administrators paid particular attention to students who came from an educationally disadvantaged area or students who represented the first generation in their families to attend college or professional school. "This recognizes that students who are able to perform reasonably well in college and who have overcome adversity to do so would be valuable members of the medical profession," Dr Guckian said.

The new criteria also gave extra consideration to students from medically underserved areas. Texas has many rural and inner-city areas that suffer from chronic shortages of physicians, particularly in primary care. "Students who come from these areas are more likely to return there to practice medicine," Dr Guckian explained. "It's not likely, for example, that someone who grew up in River Oaks is going to the Fifth Ward to practice. It's not likely that a student who grew up in Highland Park is going to Terlingua to practice medicine."

Last fall, UT medical schools interviewed more students than ever before. Of those interviewed, offers of admission were extended to 72% more African Americans and 31% more Hispanics than in 1997. The average MCAT score of these students was 29.7, compared with 30.1 in 1997, while the new students had college grade point averages of 3.64, compared with 3.66 in 1997.

Texas medical schools are still a long way from graduating doctors in ratios that match the population as a whole. "Our problem in Texas is that we need more qualified minority applicants," Dr Guckian said. "The success rate of minorities who enter our medical schools is equivalent to the success rate of nonminorities. But if we're ever going to have more minorities practicing medicine in Texas, it will be because we succeed in getting the minority students to go to college, be successful in college, and subsequently enter medical school."

> "Our problem in Texas is that we need more qualified minority applicants. The success rate of minorities who enter our medical schools is equivalent to the success rate of nonminorities."

Expanding diversity

Two other efforts to address the diversity question are under way at Texas A&M University, Baylor College of Medicine, and The University of Texas-Pan American. Texas A&M has initiated Partnership for Primary Care, while Baylor College of Medicine (BCM) and UT-Pan American have established the Premedical Honors College.

The A&M program is focused on recruiting students from medically underserved areas and offers qualifying students a chance to be accepted into college and medical school at the same time. The BCM/UT-Pan American program allows South Texas high school students who complete all of the Premedical Honors College and BCM requirements to be accepted into BCM when they grad-

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uate from UT-Pan American. (See "Producing Physicians for South Texas," January 1999 *Texas Medicine*, pp 52–57.)

Students in the A&M program do not have to take the MCAT and are guaranteed admission into medical school as long as they maintain at least a 3.5 grade point average throughout college. "We believe by recruiting students from underserved areas, we will achieve a diversity that reflects the diversity of the population of the state," said Michael Friedland, MD, vice president for health affairs and dean of medicine at Texas A&M University Health Science Center in College Station.

To be eligible for the program, high school seniors must come from an area designated as medically underserved by the US Department of Health and Human Services. The students must have grade point averages of 3.5 or better, be ranked in the top 10% of their graduating classes, and have Scholastic Aptitude Test scores of 1,200 or better. They must be US citizens or permanent residents and must enroll at a participating Texas A&M University System campus.

In its first year, seven students have enrolled in the program. The students will receive special mentoring and opportunities to explore rural health care possibilities throughout their undergraduate careers. Upon graduation from college, program participants will continue their studies at Texas A&M University College of Medicine and work in underserved areas during their last 2 years of medical school. "They are encouraged to do their residencies in underserved areas and, hopefully, they will return to practice in underserved areas," Dr Friedland said.

Partnership for Primary Care is similar to a program Dr Friedland developed in upstate New York. He sees this as another way for Texas A&M to fulfill its mission as a land-grant school charged with focusing on the needs of rural Texas.

Breaking down barriers

While The University of Texas and Texas A&M look for ways to encourage a diverse group of students to apply to medical school, lack of funds remains a barrier to many potentially qualified

students, particularly minority students. "One of the things we have to do is increase the number of scholarships available so that students who are from economically disadvantaged backgrounds have available to them funds to stay in school," Dr Guckian said. "That's true regardless of ethnicity, but realistically there are a larger number of minority students who could make it in college and who need financial assistance."

Unlike Texas, many other states don't have to contend with the *Hopwood* decision. Their state schools are free to offer scholarships based on ethnicity. Many qualified minority applicants accept scholarships at out-of-state medical schools, decreasing the likelihood of their returning to Texas to practice medicine. This "brain drain" was one topic discussed at the Forum on Post-*Hopwood* Recruitment of Minority Medical Students, held in conjunction with TMA's 1998 Fall Leadership Conference.

One way to keep promising students in Texas is to offer scholarships to Texas medical students. Though the *Hopwood* decision prohibits publicly supported medical schools from offering special scholarships to minorities, as a private organization, TMA faces no such barriers. Last April, TMA's House of Delegates approved the formation of the TMA Minority Scholarship Program to provide educational assistance to underserved minorities who wish to enroll in Texas medical schools. The students will be encouraged to remain in the state to practice upon completion of their education.

"The dollar amount we can offer can't compete with some out-of-state schools, but we hope it will be enough to make a difference to some students," said Marcia Collins, director of the TMA Medical Education Policy Department. "This sends a message that organized medicine does care about diversity in medical education."

Fundraising began in November, with TMA President John P. Howe III, MD, making the first donation. TMA hopes to award the first scholarship in May 1999. The number of scholarships awarded depends on the generosity of donors. Members may send contributions to the TMA Minority Scholarship Fund to Marcia Collins, Texas Medical Association, 401 W 15th St, Austin, TX 78701.

"The dollar amount we can offer can't compete with some out-of-state schools, but we hope it will be enough to make a difference to some students. This sends a message that organized medicine does care about diversity in medical education."

Other efforts

Meanwhile, TMA also is looking at other efforts to increase diversity in Texas medical school enrollment. In July, the TMA Board of Trustees adopted a statement, which was approved by the House of Delegates in November, recognizing the negative impact of *Hopwood v Texas* on underrepresented minority enrollment in Texas medical schools and pledging TMA's support of efforts to reverse this negative effect.

In July 1998, the American Medical Association voted to file an amicus curiae ("friend of the court") brief in support of The University of Texas' appeal of the *Hopwood* decision. TMA is anticipating joining the AMA as a cosponsor of the brief. ★

Cynthia S. Myers is a freelance writer in Wimberley, Tex.

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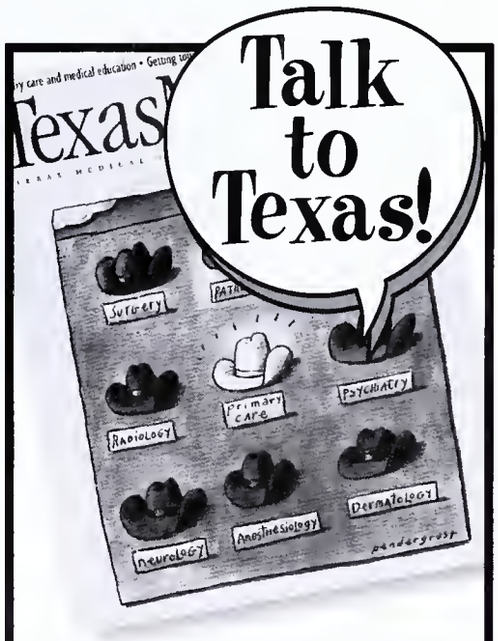

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Checking the pulse

Survey paints a dark picture of Americans' view of health care

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The economy is good and the crime rate is down, but Americans believe their health care system is in trouble and is likely to get worse in the coming years, according to a national survey commissioned by Baylor College of Medicine and Texas Children's Hospital in Houston. Physicians, for example, believe by a ratio of 10:1 that health care will be more difficult to provide in the next 5 years. ➤➤

By Larry BeSaw, Managing editor

Conducted by Louis Harris and Associates, the survey of nearly 3,000 physicians, employers, congressional staff members, state legislators, and the general public measured attitudes and concerns about the future of the health care delivery system. It examined the nation's views about health care coverage, quality, access, and costs; major economic trends in the health care industry; and health policy issues. Its findings show a large majority of Americans believe that in the next 5 years, problems with access to general and specialty medical care will become worse and many more people will not be able to afford the care they and their families need.

Increasing concerns over managed care and its limits on patient care, encroachments into physicians' ability to treat patients as they see fit, patients' frequent need to switch doctors because of changes in their insurance coverage, the rising costs of health care, and increasing numbers of uninsured patients appear to be taking their toll on the public's confidence in the health care system.

Surveyors say the public now believes the system is "eroding on all fronts — in access, cost, coverage, and quality — with substantial minorities of Americans believing that the quality of their health care services has declined and difficulty in accessing medical care increased in the past 5 years."

Most Americans believe that minor changes to the health care system will not be enough and that a joint effort by the government and the private sector will be needed to fix the system. "Most people look to the government to ensure the quality of health care and provide health care coverage to those who need it, and they are willing to vote for candidates who help solve these problems," an executive summary of the survey findings declared. "Few are willing to continue spending more of their own money to sustain their access to high-quality care."

The survey shows almost half of the public believes a major change is needed and more than 80% are willing to vote for a candidate who will support legislation to improve the quality of health care. But people don't trust either the private sector or the government alone to solve the problem. Nearly 90% of Americans believe the answer to America's health care problems lies in a public and private sector partnership.

Ralph Feigin, MD, president and chief executive officer of Baylor College of Medicine, says the survey was conducted because changes in the system during the past decade directly impact the school's primary missions of education, patient care, and research. "To achieve our missions, we thought it was important to measure what key stakeholders were feeling about the changes in the health care system and their concerns about the future of health care," he said.

Dr Feigin, who is also physician-in-chief of Texas Children's Hospital, says the survey results point to widespread concern and dissatisfaction with health care in this country. The move to managed care and other changes in the health care system have lowered costs, but Dr Feigin says it has exacted a toll. "The bottom line is the cost of health care has been constrained to some extent from the rapid inflationary increases we saw earlier, but it has come at a significant cost, and that cost has been dissatisfaction," he said.

71% [of physicians] say limitations on the services they provide to patients will be greater.

62% [of physicians] say they will have difficulty spending the current amount of time with patients.

Physicians' concerns

Like the rest of the public, physicians are worried about the future of health care in America. Many believe their costs of providing care will increase by more than 6% per year over the next 5 years, and they worry these financial pressures will prevent hospitals and doctors from giving patients the care they need.

Other important physician concerns revealed by the survey include:

- 71% say limitations on the services they provide to patients will be greater.
- 62% say they will have difficulty spending the current amount of time with patients.
- 60% believe they will have difficulty keeping relationships with the same patients.
- 55% say they will have difficulty providing care that both they and their patients feel is necessary.
- 58% say they will have difficulty referring adult patients to specialists.
- 43% say they will have difficulty referring children to specialists.

The concerns expressed by physicians responding to the survey provide evidence of doctor discontent with the state of America's health care system. In an editorial in the November 19, 1998, issue of the *New England Journal of Medicine,* Jerome P. Kassirer, MD, says many physicians "are unhappy with the quality of their professional lives." Limitations on their capacity to make independent clinical decisions, inability to refer patients to appropriate specialists or to prescribe optimal drugs, and financial incentives that strain their professional principles are just a few of the factors frustrating physicians, Dr Kassirer said.

"There has been an undercurrent of unhappiness among physicians for many years, but the complaints seem more widespread," he wrote. "One thing we know: Disgruntled, cranky doctors are not likely to provide outstanding medical care. Payers, insurers, and legislators must recognize this predicament and stop pretending doctor discontent doesn't matter."

Rampant pessimism

According to the survey, concern about

America's uninsured and underinsured is also widespread. This seems particularly unsettling with regard to children. For instance, nearly 8 out of 10 adults fear that the number of uninsured children will increase during the next 5 years. Nearly 9 out of every 10 Americans (88%) believe the government should provide health insurance coverage to children who need it, and 74% want the government to provide coverage to adults who need it.

Among other findings, the survey showed that:

- A large majority of Americans (83%) expect the number of people unable to afford medical care when they are seriously ill to increase in the next 5 years.
- More than 8 in 10 Americans (84%) expect the number of people unable to get specialty care when they are seriously ill to increase in the next 5 years.
- A large majority expects an increase in the number of people who will be unable to pay for nursing home or home care. Nine out of 10 members of the public, including physicians and employers, expect such an increase.
- Nearly 8 in 10 adults (78%) think the number of people who will be unable to afford medical care for a seriously ill child will increase.

Nearly 9 out of every 10 Americans believe the government should provide health insurance coverage to children who need it.

- 30% fear their employers will stop providing health care insurance or severely limit coverage in the future.

"The safety net is not working and it's expected to get worse," said Arthur Garson, Jr, MD, senior vice president and dean for academic operations at Baylor College of Medicine. "When a significant majority of Americans believe that they won't be able to afford health care and that the quality of care will worsen in the next 5 years, that's a clear indication that there are serious problems with the basic system. These problems must be acknowledged and addressed in both the public and private sectors."

The pessimism about the health care system is troubling, Dr Feigin says, because the quality of health care has never been higher. Almost daily advances in technology and development of new drugs mean Americans are getting better health care than ever before.

Nearly 8 out of 10 adults fear that the number of uninsured children will increase during the next 5 years.

Worries at work

Many Americans fear their employers will begin curtailing health care benefits, and the survey results indicate those concerns are well founded. The survey reveals that in the next 5 years, 92% of employers likely are to respond to rising health care costs by making one or more of the following changes:

- Shift more employees into managed care plans;
- Employ more part-time workers and/or shift full-time workers to part-time jobs without health care benefits;
- Introduce a defined-contribution plan for employees;
- Shift more retirees into managed care plans;
- Introduce a defined-contribution plan for retirees; and/or
- Drop some or all health care coverage for employees, dependents, or retirees.

The Texas view

An analysis of the responses of Texas residents in the survey show some interesting differences in viewpoints between Texans and the rest of the nation:

- 52% of Texans responding to the survey believe their personal health care costs will be much higher 5 years from now, compared with 44% nationally.
- 42% of Texas residents are worried about being able to afford medical care for their children, compared with 51% nationally.
- 67% of Texans believe the government should provide health insurance coverage to all adults who need it, compared with 74% nationally.
- 27% of Texans believe ensuring sufficient health insurance coverage for all people is a top health care priority, compared with 36% nationally.

Although many Texas residents are willing to vote for changes in the health care system to improve the quality and affordability of health care, they are more likely to consider longer waiting times to lower their out-of-pocket expenses.

Can we talk?

Now that Baylor officials have the survey results in hand, the question is, how do they deal with the views expressed by the participants? The first step is to hold a conference later this year to bring together what Dr Feigin calls the "leading thinkers" in the field "to see what the opinions are and what kind of ideas people have as to how to address this problem."

Dr Garson adds that because Baylor works with both the public and private sectors to educate physicians and deliver patient care, it has "a unique responsibility to act on the survey results and contribute to the ongoing debate about the future of health care in America."

The conference, he said, "could help define the scope and role of a public-private partnership." ★

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Practice patterns of rural Texas physicians trained in a full-service family practice residency program

RICHARD A. YOUNG, MD
ALAN N. BYRD, MD

The family practice residency program of John Peter Smith Hospital (JPSH) emphasizes "full-service" training to enable its graduates to provide a wide range of services to underserved areas, particularly rural communities. The purpose of this study was to investigate the practice patterns of rural JPSH family practice graduates.

Of 180 identified JPSH family practice residency graduates who currently practice in rural Texas, 102 (57%) responded to a postcard survey. Data were analyzed by decade of graduation. Recent graduates were more likely to provide obstetrical care than were older graduates. The proportion of graduates providing obstetrical care at some time during their careers was similar. Recent graduates were more likely to perform office-based procedures such as colonoscopy and esophagogastroduodenoscopy. Rural JPSH family practice graduates provided more obstetrical care, critical care, and office-based procedures than did other rural members of the American Academy of Family Physicians.

Practice patterns of JPSH family practice graduates have changed little over the past 30 years, except that recent graduates do more obstetrics and perform more endoscopies. These data show that the skills and knowledge of full-service family physicians are still needed in rural Texas.

Dr Young, clinical associate professor, and Dr Byrd, clinical associate professor, Department of Family and Community Medicine, John Peter Smith Hospital, Fort Worth, Tex. Send reprint requests to Dr Young, Department of Family and Community Medicine, John Peter Smith Hospital, 1500 S Main, Fort Worth, TX 76104.

INTRODUCTION

John Peter Smith Hospital (JPSH) in Fort Worth, Tex, has provided postgraduate medical education since 1918. The training of generalists has always been emphasized, as manifested by a rotating internship until about 1963, when a 2-year curriculum in general practice was created. This was replaced in 1973 with a residency in the new specialty of family practice.

Since its inception, the family practice residency program has placed special emphasis on training family physician graduates to provide the most complete range of services. This enables these "full-service" family practice graduates to provide a full range of patient care to underserved areas, particularly rural Texas communities. The JPSH family practice residency program is the largest in the nation at a single hospital. Its graduates currently serve approximately 90 rural Texas communities (Fig 1).

Several investigators have studied the practice patterns of rural family physicians (1–7). In general, these studies concluded that rural family physicians provide a wider range of services than their urban counterparts,

Fig 1. Texas communities currently served by graduates of the John Peter Smith Hospital family practice residency program.

Table 1. Obstetrical care.

Service	1959–1969 (n=11)	1970–1979 (n=29)	1980–1989 (n=36)	1990–1995 (n=24)	Statistics	All Graduates (n=102)	AAFP Rural Survey
Provided obstetrical care at some time in career (%)	73	62	61	83	NS	64	NC
Provided obstetrical care in the past (%)	55	21	17	8	NS	20	NC
Currently provide obstetrical care (%)	18	41	44	75	$X^2 = 8.4$, $P < .05$	44	37
Perform cesarean sections (of those doing obstetrics) (%)	100	100	94	83	NS	92	37
Deliveries per year	85	65	72	50	NS	63	NC
Why not provide obstetrical care (of those who currently do not)?							
Just not interested (%)	22	18	10	33	NS	17	NC
Limited by local "turf" battles (%)	0	18	0	16	NS	7	NC
Fear of liability (%)	33	53	40	33	NS	41	NC
Cost of liability (%)	55	53	40	33	NS	44	NC

AAFP = American Academy of Family Physicians
NC = no comparable AAFP data
NS = nonsignificant

particularly in obstetrics. No study was identified that examined changes in practice patterns by year of training.

The purpose of this study was to investigate the practice patterns of JPSH family practice residency graduates currently serving rural Texas communities. Special emphasis was placed on examining the provision of obstetrical care, critical care, surgical care, and office-based procedures to determine how practice patterns have changed by decade of graduation.

METHODS

A list of alumni was created for all graduates of the JPSH family practice residency program and its predecessors back to 1959, chosen because a graduate of that year would be aged approximately 65 years in 1996.

Efforts were made to ascertain the current location of each graduate by using the last known address furnished by the hospital, the Texas Academy of Family Physicians, and the Texas Medical Association. We could identify the current practice location of more than 92% of our graduates.

Rural practice locations were identified by using the state definition: towns of less than 30,000 population not close to an urban area. Letters were mailed to all rural residency graduates. The survey instrument was a return-addressed postcard that consisted mostly of questions where answers could be checked off. A section for open-ended comments was provided. A second round of postcard surveys was sent to those who did not respond to the first inquiry.

Graduates who are not currently practicing and those who completed other residencies or fellowships and are not practicing family medicine were excluded from this analysis. Graduates were grouped by decade of graduation to analyze trends over time. Most data were nonparametric and were analyzed with chi-square. Parametric data were analyzed with Student's *t* test. Practice patterns of rural JPSH graduates were compared qualitatively to practice patterns of other rural family physicians, as reported by the American Academy of Family Physicians (AAFP) (1).

RESULTS

We identified 180 graduates who practice in rural Texas. Of these graduates, 102 (57%) responded to the survey. Two respondents did not write their names on the survey; therefore, their graduation years could not be determined. Their responses were not included in the comparison by year of graduation but were included in the overall statistics.

Table 2. Surgical care.

Service	1959–1969 (n=11) %	1970–1979 (n=29) %	1980–1989 (n=36) %	1990–1995 (n=24) %	Statistics (for trend)	All Graduates (n=102) %
Appendectomy — primary	45	31	17	30	NS	28
Herniorrhaphy — primary	45	21	11	13	NS	19
Cholecystectomy — primary	9	0	9	0	NS	5
Tubal ligation — primary	45	41	47	71	NS	51
Appendectomy — assist	27	34	64	35	NS	45
Heniorrhaphy — assist	27	36	63	46	NS	48
Cholecystectomy — assist	60	52	69	54	NS	60
Tubal ligation — assist	27	14	17	9	NS	15

NS = nonsignificant

Table 3. Critical care.

Service	1959–1969 (n=11) %	1970–1979 (n=29) %	1980–1989 (n=36) %	1990–1995 (n=24) %	Statistics (for trend)	All Graduates (n=102) %	AAFP Rural Survey
Manage critically ill patients	91	93	92	92	NS	92	72
Intubation	100	86	89	100	NS	91	NC
Manage ventilators	64	79	83	100	NS	81	NC
Initial ventilator stabilization only	9	29	17	46	NS	25	NC
In-hospital ventilator management	55	50	67	54	NS	56	NC
Management of potent intravenous drugs	64	93	89	100	NS	89	NC

AAFP = American Academy of Family Physicians
NC = no comparable AAFP data
NS = nonsignificant

Obstetrical care

Practice patterns as a function of decade of graduation are shown in Table 1. A statistically significant increase in the proportion of recent graduates providing obstetrical care was identified (75% of recent graduates, $P < .05$). The proportion of graduates who have provided obstetrical care has remained fairly stable over the years. (The proportion of graduates who practiced obstetrics may be higher than that reported; that specific question was not asked. It is reported here because so many respondents wrote in the comments section that they provided obstetrical care in the past).

Those who do not provide obstetrical care were asked why they did not. More than 40% of respondents reported that the fear and cost of medical liability were important factors in this decision. (The percentages total more than 100%, because more than 1 response was allowed). Lack of interest in obstetrics and "turf" battles were less important factors.

Surgical care

Practice patterns as a function of decade of graduation are shown in Table 2. No

Table 4. Office-based procedures.

Procedure	1959–1969 (n=11) %	1970–1979 (n=29) %	1980–1989 (n=34) %	1990–1995 (n=24) %	Statistics (for trend)	All Graduates (n=102) %	AAFP Rural Survey
Flexible sigmoidoscopy	27	48	65	67	NS	56	47
Colonoscopy	0	14	12	42	$X^2 = 9.9$ $P < .05$	19	5
Esophagogastroduodenoscopy	0	7	20	42	$X^2 = 10.6$ $P < .05$	19	6
Nasolaryngoscopy	0	14	11	33	NS	16	NC
Colposcopy	27	34	25	67	NS	38	15
Loop electrical excisional procedures	9	21	8	38	NS	19	NC
Vasectomy	45	55	51	67	NS	57	NC

AAFP = American Academy of Family Physicians
NS = nonsignificant
NC = no comparable AAFP data

Table 5. Other services.

Services	1959–1969 (n=11)	1970–1979 (n=29)	1980–1989 (n=34)	1990–1995 (n=24)	Statistics (for trend)	All Graduates (n=102)	AAFP Rural Survey
Admit pediatric patients (%)	73	93	100	100	NS	94	NC
Provide neonatal resuscitation (%)	44	65	82	96	NS	76	NC
Cast and manage closed fractures (%)	80	85	89	92	NS	87	58
Frequency of first call in local emergency room (days/month)	2.9	4.6	5.9	5	NS	5	NC
Serve as high school team physician (%)	20	37	35	57	NS	39	NC

AAFP = American Academy of Family Physicians
NS = nonsignificant
NC = no comparable AAFP data

significant trends were identified. No comparable AAFP data were identified for any of the categories.

Critical care

Practice patterns as a function of decade of graduation are shown in Table 3. No significant trends were identified. Most graduates across the years provide critical care services.

Office-based procedures

Practice patterns as a function of decade of graduation are shown in Table 4. Significant increases in the provision of colonoscopy and esophagogastroduodenoscopy were identified (42% of recent graduates, $P < .05$ for both procedures). A nonsignificant trend towards increased provision of other procedures such as flexible sigmoidoscopy, nasolaryngoscopy, colposcopy, and loop electrical excisional procedures was observed.

Other services

Practice patterns as a function of decade of graduation are shown in Table 5. No significant trends were observed. Graduates across the years continue to provide a large amount of pediatric hospital

care, neonatal resuscitation, closed fracture management, and first call to local emergency rooms.

DISCUSSION

This study documents the wide range of health care services provided to rural Texas by graduates of a full-service family practice residency program. The study has the same weaknesses as other survey-based research. Biases created by incomplete survey responses and self-reporting are acknowledged.

Overall, the practice patterns of rural JPSH graduates have changed very little over the last 30 years. The major trend observed is that recent graduates provide more office-based procedures, particularly endoscopies, and more obstetrical care. In general, a higher percentage of JPSH graduates than rural family physicians trained elsewhere provide obstetrical care, critical care, and procedural services.

Future research should continue to monitor the actual practice indicators of rural family practice graduates to ensure that the educational experience provided during residency training matches the skills needed to serve rural Texas. Additional information about the experiences of rural graduates from other family practice residencies would be useful. More data on the quality and outcomes of services provided by rural family physicians are needed.

This study demonstrates that graduates of a full-service family practice residency program are able to use the skills and knowledge learned during their training when they practice in rural Texas. Full-service family practice residencies still play a crucial role in preparing young physicians to provide health care to the people of rural Texas.

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The pediatrician's role in child abuse

Position statement of the Texas Pediatric Society, a chapter of the American Academy of Pediatrics, Committee on Child Abuse

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Child abuse encompasses neglect and the physical, emotional, and sexual abuse of children. Children who witness violence and suffer its detrimental effects (1–3) are victims of another type of child abuse. Every pediatrician who treats children has treated an abuse victim. For example, sexual abuse of children is estimated to be more prevalent than asthma in children and affects an estimated 20% of female children and teenagers (4,5). With regard to physical abuse, more conservative estimates indicate that 20% of children are victims of severe physical punishment (6).

In 1994, Texas was third in the nation in absolute numbers of child abuse reports (7). In 1995, more than 50,000 children in Texas were confirmed victims of child abuse (8). In the same year, the estimated number of children "at risk" for abuse in Texas was 858,133 (8). The percentage of Texas children estimated to be at risk for abuse is based on a survey conducted by the Criminal Justice Center; 16.2% of parents indicated at least 1 of their children had been abused. This marked discrepancy between confirmed and projected numbers indicates that child abuse remains an underdetected and/or underreported problem. Child abuse demands our attention and compels our action.

All pediatricians should commit to helping abuse victims, support education efforts in this field, advocate for strong child protection laws and prevention efforts, and provide a means for appropriate and sensitive treatment of victims.

Pediatricians have an important and unique role in cases of child abuse. Because they are experts in child development, they can communicate effectively with children and teenagers. Sensitivity to the developmental capability and emotional concerns or issues for each child is key to appropriate questioning when abuse is suspected. Typically, the child views the doctor as an advocate, whereas the role of law enforcement and child protective personnel may be threatening or confusing. Although pediatricians are equipped with unique skills that may be beneficial to victims of child abuse, many physicians may feel inadequately prepared to conduct a medical evaluation of an abused child, particularly if sexual abuse is suspected (9). The challenge is to determine how each pediatrician can best use his or her skills to preserve the emotional integrity of the child and to optimize the collection of physical evidence. To achieve this goal, pediatricians should know the protocols, resources, and experts available in their community.

Primary care pediatricians have the opportunity to become frontline detectors of child abuse. Clinical detection depends on knowledge of the various behavioral and physical symptoms associated with abuse. A summary of clinical indicators is provided in the Texas Medical Association's Blue Ribbon Panel on Family Violence report on child abuse and neglect (10). Education, beginning at the medical student level and updated yearly by practicing physicians, is necessary to strengthen the knowledge base, enhance detection rates, and improve evaluation of abuse victims. Continuing education in child abuse is particularly important because medical knowledge is relatively insubstantial and still evolving.

Accurate and complete documentation in cases of suspected abuse is crucial. The documentation of historical and physical findings in cases of abuse frequently is insufficient. However, documentation can be improved when physicians participate in continuing medical education (11). Another way to improve documentation is to standardize the type of information recorded. One study (12) has found that standardized forms greatly im-

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prove physician documentation in cases of abuse. Protocols and forms should be developed and implemented by residency training programs, hospitals, and clinics to facilitate appropriate and comprehensive evaluations for cases of child abuse.

Child advocacy involves intervention with the child victim, parent, community, and legislature. Strategies to prevent child abuse include educating parents and schools in the appropriate use of discipline (13), the deleterious effects of exposing children to violence in the home, community, and media (14), and the warning signs of abuse. Acknowledgment of stress associated with parenting and discussion of management strategies is one example of parent advocacy and child abuse prevention. The Texas Pediatric Society Committee on Child Abuse recommends periodic screening for domestic violence and substance abuse in family members. Examples of screening questions include "What happens when people get mad in your family? Does anyone get hurt? Does anyone use drugs or have a drinking problem in your family?"

Advocacy for abused children includes supporting legislation that strengthens the child protection system by improving investigative efficiency and accuracy and by providing for ongoing services in families where abuse or risk of abuse is identified. All sectors of society should comply with reporting provisions of the Texas child abuse laws. In accordance with the American Academy of Pediatrics (15), the Texas Pediatric Society asserts that the basic moral principles and protection of children require that all parents and caretakers must be treated equally by the laws and regulations enacted by the state and federal government to protect children; all child abuse statutes should be applied without potential or actual exemption based on religious beliefs; and no statute should permit or imply that denial of medical care necessary to prevent death or serious impairment to children can be supported on religious or cultural grounds. Multidisciplinary coordination through regionalized child protection teams, children's advocacy centers, and child fatality review teams (16,17) is essential to improving the evaluation and treatment of suspected victims of abuse. Regionalized teams of experts and peer review of abuse cases greatly promote a standard of accuracy in abuse cases.

Legislation also should support pediatricians who provide care to abused children (18). When hospitalization is a matter of necessity or safety for the child, both the hospital and physician should be compensated for services. Hospital admission under such circumstances should not be delayed or denied.

RECOMMENDATIONS

The Texas Pediatric Society has a continuing commitment to the identification, treatment, and prevention of child abuse and recognizes the need to assert medical leadership in this field. The society, therefore, makes the following recommendations:

- All state medical schools and primary care residency programs should provide education and encourage research at the graduate and postgraduate levels in the diagnosis, treatment, and prevention of child abuse.
- Physicians caring for children should develop, through continuing education, first, the skills necessary to effectively identify child abuse victims and recognize the emotional impact of all forms of abuse and neglect; second, the means to effectively evaluate, treat, or refer for evaluation and treatment cases of possible abuse; and third, knowledge of effective prevention strategies for child abuse.
- Physicians should use diagnostic and treatment guidelines to identify and manage cases of suspected child abuse. The examination and treatment of these children and adolescents should be conducted by a trained and experienced physician or by a qualified health professional under the guidance and supervision of physicians trained in this field, when possible.
- All physicians should be aware of the following:

  - The need to publicize the dangers of shaking an infant or child;
  - The adverse consequences of corporal punishment within learning institutions including schools, churches, day care centers, foster homes, residential treatment facilities, hospitals, and any facilities responsible for youth;
  - The role of substance abuse, including alcohol, in the etiology of child abuse;
  - The pernicious influence of child pornography, advertising that depicts children as sexual objects, and ritual abuse;
  - The deleterious effects that children who witness violence suffer;
  - The importance of regional child fatality review teams to determine and address preventable causes of mortality, including child abuse within the pediatric age range; and
  - The concept of children's advocacy centers and the need for a multidisciplinary approach to management of child abuse.

- Physicians should support legislation to strengthen the child protection laws in Texas. These statutes should provide for adequate funding to address the appropriate protective, health, and social services for all abused children and their families.

Among, but not limited to, the services that should be provided are home visitation programs and a regionalized statewide system of multidisciplinary teams that includes physicians and provides effective mechanisms for the evaluation and treatment of child abuse victims. This system should encompass child fatality reviews, peer review of child abuse cases, and development of protocols.

- Health care personnel and all others should comply with the reporting provisions of the Texas child abuse laws. Further, these reporting requirements should be universally applied to, and by, all sections of society.
- In cases of suspected abuse where hospitalization is deemed a matter of medical necessity or safety for the child, both the institutions and physicians caring for potentially abused children must be compensated for services they provide to these children.

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Educational Opportunities

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Emergency Medicine	March 18-20
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Family Practice	February 4-6
Abdominal (3 Day)	March 11-13
Abdominal (5 Day)	February 22-26 April 19-23
OB/GYN (5 Day)	March 1-5 April 26-30
Prostate	March 6 August 7
OB/GYN (3 Day)	March 25-27

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6th Annual Progress in Clinical Pathology, March 4-6. Le Meredian Dallas Hotel, sponsored by UT Southwestern Medical Center at Dallas. Course directors: Harold Kaplan, MD, Richard McKenna, MD. CME credit offered. Contact: Jim O'Reilly, program coordinator, (214) 648-2166.

16th Annual Dallas Rhinoplasty Symposium, March 4-6. Westin Galleria and UT Southwestern Medical Center at Dallas. Course directors: Rod Rohrich, MD, Jack Gunter, MD. CME credit offered. Contact: Leah Cannon, program coordinator, (214) 648-2166.

3rd Annual Aesthetic Surgery Symposium, March 7-9, Westin Galleria Hotel and UT Southwestern Medical Center campus. Course directors: F.E. Barton, MD, H.S. Byrd, MD. CME credit offered. Contact: Leah Cannon, program coordinator, (214) 648-2166.

Alternative Medicine, April 6, UT Southwestern Medical Center at Dallas, Gooch Auditorium. Course Director: Robert Gatchel, Ph.D. CME credit offered. Contact Stacey Novotny, program coordinator, (214) 648-2166.

PAN AMERICAN ALLERGY SOCIETY

43rd Annual Training Course & Seminar
March 10-14, 1999
Plaza San Antonio Hotel, San Antonio, Texas

Program Director: Edwyn L. Boyd, MD

Basic course in quantitative skin testing techniques designed with the primary care physician and allied health care professionals in mind. Offering 31.5 hours of CME. Inquiries: Ann Brey, Executive Secretary, PO Box 947, Fredericksburg, TX 78624. Telephone (830) 997-9853; fax (830) 997-8625.

GI Topics For The PC Physician With A Flexible Sigmoidoscopy Workshop, March 6, Simmons Biomedical Research Building, Excellence in Education Foundation Auditorium, UT Southwestern Medical Center at Dallas. Course director: William Harford, MD. CME credit offered. Contact: Lisa Dunlevy, program coordinator, (214) 648-2166.

31st Annual Kenneth C. Haltalin Pediatric Seminar: Pediatrics for the Practitioner, March 19-20, Dallas Renaissance Hotel. Course director: Joel Steinberg, MD. CME credit offered. Contact Jim O'Reilly, program coordinator, (214) 648-2166.

Comtemporary Management of Atrial Fibrillation, March 26-28, Barton Creek Conference Center, Austin. Course director: Richard Page, MD. CME credit offered. Contract Lisa Dunlevy, program coordinator, (214) 648-2166.

Ambulatory Outpatient Surgery, April 10, UT Southwestern Medical Center at Dallas. Course director: Girish Joshi, MD. CME credit offered. Contact Stacy Novotny program coordinator, (214) 648-2166.

Recent Advances in HIV Medicine, April 16-17, UT Southwestern Medical Center at Dallas, Simmons Biomedical Research Building, Excellence in Education Auditorium. Course director: J.W. Smith, MD. CME credit offered. Contact: Lisa Dunlevy, program coordinator, (214) 648-2166.

Southwestern Center for Minimally Invasive Surgery: Hernia Advances in Surgery, April 22-23. UT Southwestern Medical Center at Dallas, Excellence in Education Foundation Auditorium, Simmons Biomedical Research Building. Course director: R.V. Rege, MD. CME credit offered. Contact: Leah Cannon, program coordinator, (214) 648-2166.

February 19-21: Texas Neurological Society will hold its second annual Winter Conference, Austin Marriott at the Capitol. The theme is "The Cycle of Neurological Life: Therapeutics in Neurology." It will cover topics from pediatric through mid-life, to end-of-life: neuromuscular disease, headaches, epilepsy, MS, Guillian Barre, brain tumors, genetics, stroke, Parkinson's. One hour of ethics will also be offered. Contact Rachael Reed, Executive Director at (512) 370-1532, or (800) 880-1300, ext. 1532, fax (512) 370-1626, or rachael r@texmed.org.

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BackTalk

Question

What clinical advice would you give young physicians to help them care for their patients?

"Listen. Diagnosis is three-fourths history. And never cut them off when they say, 'Oh, yeah, doctor, there's one more thing.' That's when they're going to tell you what they really came for."

Bertram D. Garrett, MD, 51
family practice, Austin

"It may be true that there is no such thing as a 'poor historian.' Learn to ask the right questions. Learn to be a good listener. Sincere concern for your patient expressed through thoughtful listening can be therapeutic."

Sandra A. McMahan, MD, 52
pediatric allergy, Temple

"It is often surprising how forgiving patients can be if you earn their respect. So if you sense there may be a problem between you and a patient, don't be afraid to address it head-on."

Richard C. Bibb, MD, 60
psychiatry, Wichita Falls

"If you become angry at what managed care is doing to destroy high-quality health care, don't be angry at your patients. Most patients are not allowed to choose their coverage; it is chosen for them. Be angry at and fight the managed care organizations!"

Ben R. Keller, Jr, MD, 62
gynecology, Arlington

"Above all, focus all your intelligence, training, and experience on the patients whom you encounter, and try to understand their needs from their points of view."

John W. Meyer, MD, 58
family practice, Hondo

"Take time to talk to the patients and explain to them their illnesses. They appreciate it very much to know exactly what they have, and their compliance will be better."

Rowena B. Garay, MD, 54
pediatrics, Winnsboro

"There is almost a holy relationship between a patient and physician that never should dissolve. Physicians must always put patients first. When they do that, everything else will fall into place."

Laurance N. Nickey, MD, 67
pediatrics, El Paso

"Listen to your patients and understand where they're coming from. Be sincere and up front with them."

William G. Gamel, MD, 62
internal medicine, Austin

"I have a daughter who is a medical student, and my advice to her would be to listen to her patients, develop a rapport with them, and also be the patients' advocate."

Larry E. Browne, MD, 56
physical medicine, Gonzales

Back Talk is a nonscientific sampling of Texas physicians' opinions on a topic of interest. Physicians are polled by telephone, fax, or e-mail. We welcome suggestions for future topics. Send them to *Texas Medicine*, Back Talk, 401 W 15th St, Austin, TX 78701; fax them to (512) 370-1632; or e-mail them to m_mcever@texmed.org.

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Stress, burnout, and addiction

Two physicians got hooked on drugs; another just walked away from the profession to which he dedicated his life. The results of stress and burnout can be tragic, even life threatening, but they don't have to be. Recognizing what causes stress and burnout can go a long way toward preventing trouble, and the Texas Medical Association stands ready to help if problems occur.

By Johanna Franke

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Medical Economics

It just makes sense 34

Tired of all those health maintenance organization (HMO) reviewers trooping through your office and poking their noses into everything? TMA and the HMO medical directors have sat down together and come up with a standardized survey instrument that cuts down on the number of reviews and satisfies everyone.

By Laurie Stoneham

Law

See you in court? 38

Just before he headed out the door for the private sector last December, Atty Gen Dan Morales filed a major lawsuit against six HMOs over alleged violations of several state laws. The question now is, how will his successor, John Cornyn, pursue those suits? The new attorney general is noncommittal, saying only that he intends to review the cases.

By Teri Moran

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It could have been one of those legislative battles where everyone got bloody. But thanks to cooperation between TMA physicians and the pharmacists, a fight over redefining the pharmacists' role in health care appears to have been avoided.

By Ken Ortolon

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Publicity helps 58

Cooperating with the news media and letting reporters share your story with the public can help you and your patients. Here are a few tips on dealing with the media.

By Laura J. Albrecht

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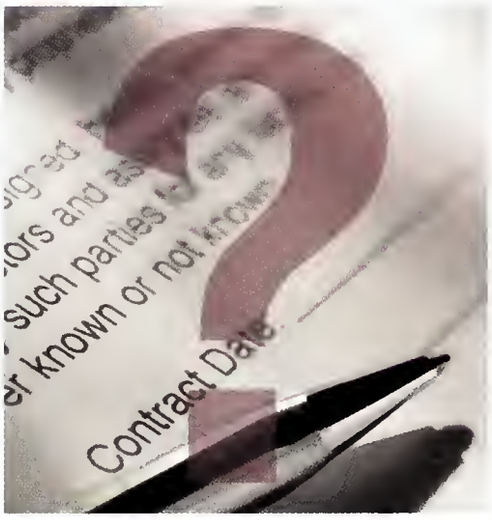

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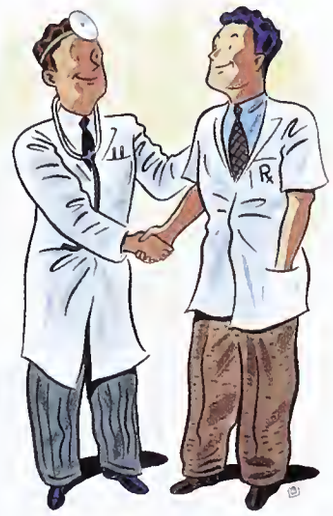

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The Big Picture

Glacier National Park, by Lawrence O. Gahagan, MD, Dallas

If you would like to submit a photograph for The Big Picture, please send it to Laura J. Albrecht, Photo Editor, *Texas Medicine*, 401 W 15th St, Austin, TX 78701.

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Editor's Note

The $40-million Texas Lottery drawing was later that day, and several of us were fantasizing about how we would quit our jobs if we won. Most of us agreed we would resign by long distance from Tahiti. One woman, however, said she might come in to get her daughter's picture off her desk. But, she added after a short pause, "I've got lots of pictures of my daughter."

Unfortunately, none of us won. But the point is we all sometimes daydream of emulating singer Johnny Paycheck and telling our bosses to "take this job and shove it. I ain't working here no more." Few of us ever do.

Physicians are no exception. Modern medicine puts more pressure than ever on doctors. For some, stress leads to burnout, and they just walk away. Others turn to drugs or alcohol and find their lives and careers in ruin. Some even resort to suicide.

In this issue, Associate Editor Johanna Franke explores physician stress and burnout, what causes it, and what TMA and others are doing about it. We meet two physicians rescued from the hell of drug and alcohol addiction, and hear from a neurosurgeon about why he gave up his lucrative practice.

Johanna's package of stories is compelling. The picture she paints is not pretty, but it's one every physician needs to look at.

Larry BeSaw
Managing Editor

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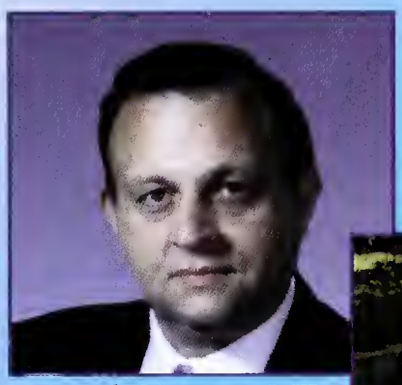

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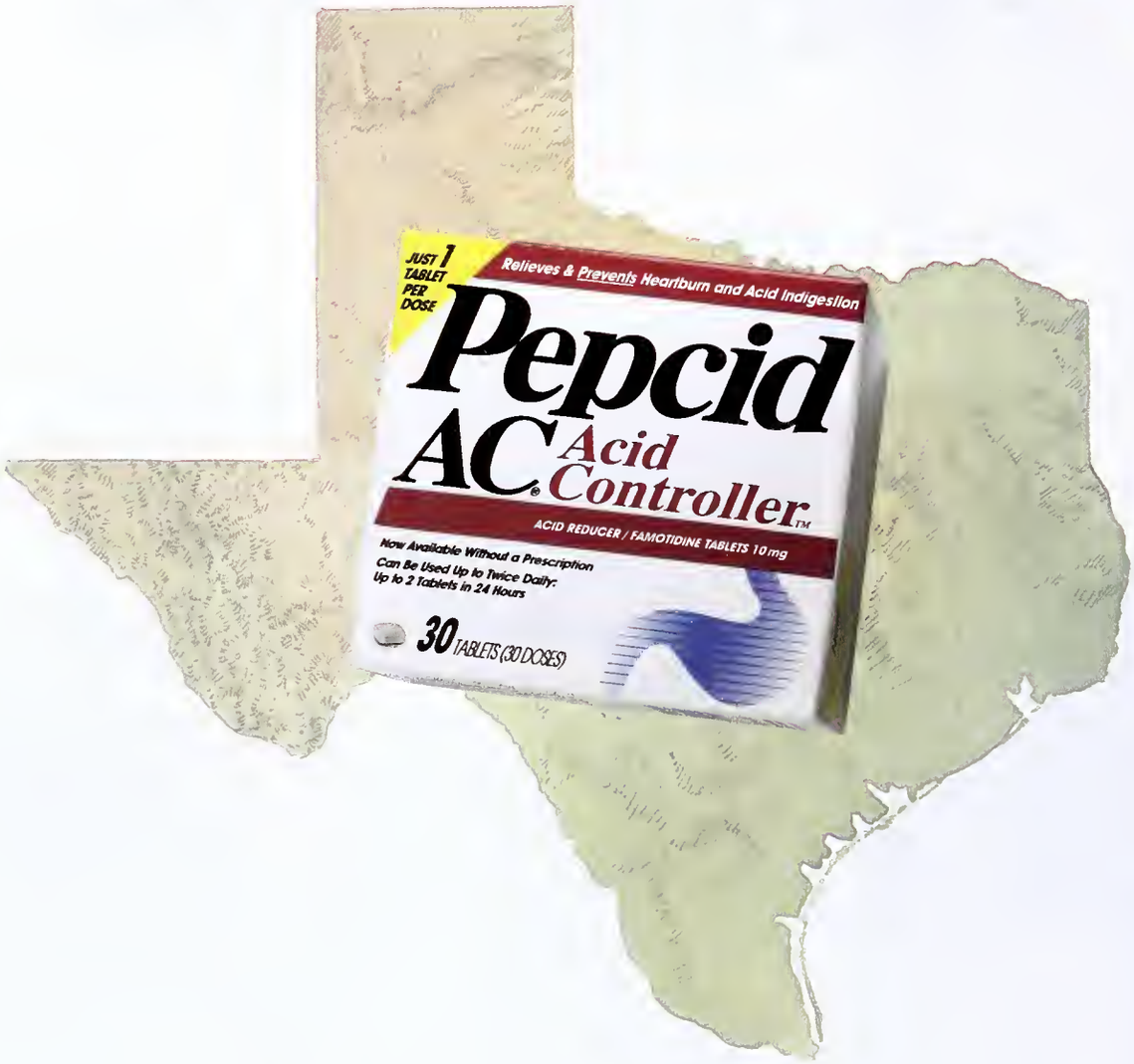

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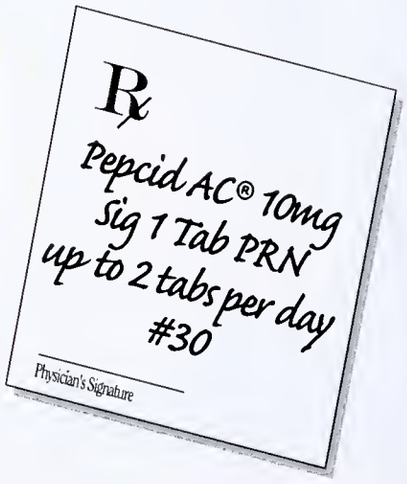

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1. IMS, 1998.
2. Decktor D, et al. A comparison of single-dose Pepcid AC vs. Prilosec 10 mg and 20 mg on human gastric acid secretion. American College of Gastroenterology 62nd Annual Scientific Meeting. Abstract. 1997.
3. 1998 Drug Topics®, *Red Book® Update.*

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Letters

Concerns still there

As a physician caring for poor women in San Antonio, I have an intense interest in the funding for family planning clinics in Texas. These clinics are the main (and often the only) source for preventive care for uninsured women. The Texas Medical Association House of Delegates also is concerned. In November 1998, the House approved Bexar County Medical Society's resolution supporting funding for family planning clinics.

I was pleased to read in the December issue of *Texas Medicine* ("Setting the Record Straight," pp 32–35) that the Texas Department of Health (TDH) does not intend to cut family planning funding. However, it is not clear that TMA should be reassured. Dr Archer's (Texas Commissioner of Health William R. Archer III, MD) comments indicate that funding for family planning *clinical services* may indeed be cut. The intention appears to be to move funds from clinics to population-based programs. Unfortunately, loss of funds to family planning clinics will mean that many uninsured women will no longer have access to preventive care. These women have no "medical homes."

At the time of this writing, it appears that clinics will apply for extensions for Title V funding for fiscal year 2000. This suggests that funding will be level for the year that begins in September 1999. However, TDH has not made clear its intentions concerning funding for clinics. The severe cuts proposed in the legislative appropriations request have not been rescinded in writing, in spite of requests for written clarification from the TMA Council on Public Health and the TMA Ad Hoc Committee on Sunset.

I am not yet reassured.

Janet P. Realini, MD, MPH
332 W Commerce, Ste 303
San Antonio, TX 78205-2409

Unfortunately, loss of funds to family planning clinics will mean that many uninsured women will no longer have access to preventive care.

Dr Archer on the right track

I was confused by the article "Setting the Record Straight" (December 1998 *Texas Medicine,* pp 32–35) by Teri Moran. I thought I was going to learn about a change in public health policy, but instead the article was devoted entirely to uninformed speculation by non-policymakers and personal testimonials from poor patients.

Nowhere in the article does it mention the entire amount of money that is spent for family planning services in Texas. In the final paragraph, we finally learn that Dr Archer does not plan to reduce the amount of tax dollars spent on public health and, in particular, family planning, but wants to see family planning delivered in the context of comprehensive medical care. Certainly, this does not appear to be the case at present; if so, why are they called family planning clinics? Certainly, a comprehensive public health program for the poor should not use sex as the point of entry into health care.

Also, family planning clinics, by their nature, do not provide health care for poor men. Certainly, the family planning clinics fear change, just as any ingrained institution, but they are certainly ripe for improvement and new ideas, and I believe Dr Archer is the person who can provide them. Certainly, he is asking the right questions.

Brian B. Berger, MD
3705 Medical Parkway, Ste 410
Austin, TX 78705-1023

Express your point of view in *Texas Medicine*. To submit a letter, mail, fax, or e-mail it to *Texas Medicine*, TMA, 401 W 15th St, Austin, TX 78701; fax (512) 370-1632; e-mail larry_b@texmed.org. Please type letters you submit for publication, and keep the length to 400 words or less. If necessary, you may include a few references, preferably less than five. Letters are published at the discretion of the managing editor and editorial advisors, and are subject to editing and abridgment. Letters represent the opinions of the authors and do not necessarily reflect the policies of the Texas Medical Association.

A lifesaving exam

A prostate self-examination (PSE) may save your life. It did mine. Women do breast self-examination. Men should do prostate self-examination. Digital examination once or twice a year is not often enough to have your prostate examined.

In early 1994, my prostate-specific antigen (PSA) blood test result was 3.5, and the doctor's digital examination was negative. Several months later, I decided to do a PSE and felt a firm lump, about 6 mm, on the top left border of my prostate. I went to my urologist, who examined me and ordered a sonogram and biopsy. Three biopsies out of five revealed carcinoma (Gleason 7). A repeat PSA was still normal. I had a radical prostatectomy, and the pathology examination showed the tumor to extend beyond the edge of resection. The regional nodes were negative, and the bone scan was negative. I had follow-up radiation.

If I had waited a year for another checkup, I feel sure the tumor would have been in the regional nodes, if not in some distant sight. A PSA is helpful but cannot be relied on entirely. False-positive results are fairly common, and false-negative ones are not uncommon.

A PSE is so easy, painless, and simple. I encourage you to do it on yourself and teach your patients to do it. Anyone can do it and tell if the prostate is uniformly lumpy as in benign prostatic hyperplasia, if one lump is harder or bigger this month than last month, or if a lump is present that wasn't last month.

The Schaffer procedure can be done in less than 5 minutes. A man sits on the commode, spreads his legs wide apart, holds up his genitalia with one hand, applies Anusol to the middle finger of the other hand, and inserts it into his rectum. If he has difficulty feeling the upper margin, he bears down as in a bowel movement, which pushes the prostate down and allows him to feel the upper aspect very easily.

Recently, a doctor told me he had been doing PSE for 10 years and about a year ago found his own cancer of the prostate. Surgical removal revealed free margins, and he didn't need further treatment.

I'm convinced that when most men over age 50 (preferably over age 40) begin doing PSE, the death rate from prostate cancer will go way down.

I'm convinced that when most men over age 50 (preferably over age 40) begin doing PSE, the death rate from prostate cancer will go way down.

Richard C. Schaffer, MD
3920 W Vickery Blvd
Fort Worth, TX 76107

Help your staff help you

Although I am not a physician, I subscribe to your magazine as a valuable tool for my profession. I have been in the medical field for more than 20 years in multiple specialties and I am classified as a reimbursement and practice management specialist. I work for several physicians in different fields, which gives me a unique insight into the daily problems associated with managed care.

I would like to offer a suggestion to assist physicians in "taking back your profession." It would be beneficial to note that physicians have relatively little direct contact with the managed care environment. Physicians primarily are impacted peripherally (other than financially) by the day-to-day frustrations and stonewalling from insurance carriers. Office staff members are on the frontline of battle. We are the soldiers on the telephone for hours attempting to obtain referrals, authorizations, and precertifications, and to effect appeals. I rarely have to involve a physician directly with an insurance carrier. My personal background and performance level are such that my physicians are, for the most part, ultimately protected from the hassles and frustrations associated with the managed care environment. This has advantages and obvious disadvantages.

Because our offices are so busy, I am able to run a smooth patient flow on a daily basis. However, this also insulates the physician from the true level of irritation and unbelievable lack of concern and knowledge on the part of the insurance company staff. Therefore, most physicians do not participate more fully because they are not on the frontline fighting these battles every day.

In any specialty, the office staff can make or break success. We as staff members are considerably better prepared to unite and fight the managed care battles alongside physicians. We are competent and have well-defined skills in this arena of struggle. We have almost as much to gain or lose as do physicians because this is our job, our chosen field, and in most offices, our family. Imagine what your organization could do if you tapped into the resources available right under your nose — your own staff. We can be a formidable group of individuals and, united with our physicians, could literally move the mountains of managed care. Involve us, make a place for us. We are the warriors on the side of the physician and patient.

We as office staff members learned long ago how to rise above our differences and help each other make our own lives and the lives of our patients better. Give us the opportunity to work side by side with you in an arena of united power. Texas physicians would be a force to be reckoned with.

Tracy Warrick
708 Horizon Dr
Murphy, TX 75094

People

Newsmakers

The 1999 Brazos-Robertson County Medical Society officers include ophthalmologist **Charles W. Akins, MD,** College Station, president, and diagnostic radiologist **Ronald M. Rust, MD,** College Station, secretary-treasurer.

Two Houston plastic surgeons, **Bernard M. Barrett, Jr, MD,** and **Saleh M. Shenaq, MD,** were honored by the Physicians for Peace Foundation for their volunteer services.

Houston internist **Alan Buchman, MD,** received the Southern Medical Association's 1998 Seale Harris Award for his significant contribution to a better understanding of the chemical changes occurring in disease.

Houston cardiovascular surgeon **Denton A. Cooley, MD,** received the 1998 National Medal of Technology, the nation's highest honor for technological innovation, from the Office of Technology Policy of the US Department of Commerce.

Houston nuclear medicine specialist **Ebrahim S. Delpassand, MD,** was elected president of the Society of Iranian-American Health Care Professionals of Texas.

Charles W. Akins, MD

Gordon Green, MD

William L. Rayburn, MD

Dan Stultz, MD

Houston neonatal-perinatal medicine specialist **Susan E. Denson, MD,** was named Physician of the Year for Hermann Children's Hospital.

San Antonio general surgeon **James Paul Dorman, MD,** received a 3-year appointment as Cancer Liaison Physician for the Hospital Cancer Program at South Texas Veterans Health Care System.

Athens family practitioner and geriatric medicine specialist **Robert Eckert, MD,** and Bay City family practitioner **Edward Pesek, MD,** were honored for 35 years of membership in the American Academy of Family Physicians.

Houston family practitioner **Srihari Gopal, MD,** received a $500 American Medical Association-Resident Physician Section Policy Promotion Grant for her community health fair project.

The 1999 Dallas County Medical Society officers include pediatrician **Gordon Green, MD,** Dallas, president; endocrinologist **Fred F. Ciarochi, MD,** Duncanville, president-elect; and pulmonary disease specialist **Randall L. Rosenblatt, MD,** Dallas, secretary-treasurer.

Clinical pathologist **Elizabeth A. Hartwell, MD,** was selected Physician of the Year for Hermann Hospital in Houston.

Dallas oncologist **John Minna, MD,** received a special award from the Susan G. Komen Breast Cancer Foundation for his dedication and commitment to eradicating breast cancer.

Houston head and neck surgeon **Walter P. Moore III, MD,** was elected 1999 chair of the Harris County Medical Society Board of Ethics.

Obstetrician-gynecologist **William L. Rayburn, MD,** was named medical director of Scott & White Clinic in College Station.

Please let *Texas Medicine* know about your honors and achievements. Criteria for inclusion in the Newsmakers section are TMA membership; election or appointment to an office of, or honors from, a national or state organization; or, space permitting, recognition at the local level. Items for the Newsmakers section are published at the discretion of the managing editor. Submit items for consideration, with photos if possible, to Johanna Franke, People, *Texas Medicine*, 401 W 15th St, Austin, TX 78701; fax (512) 370-1632; e-mail johanna_f@texmed.org.

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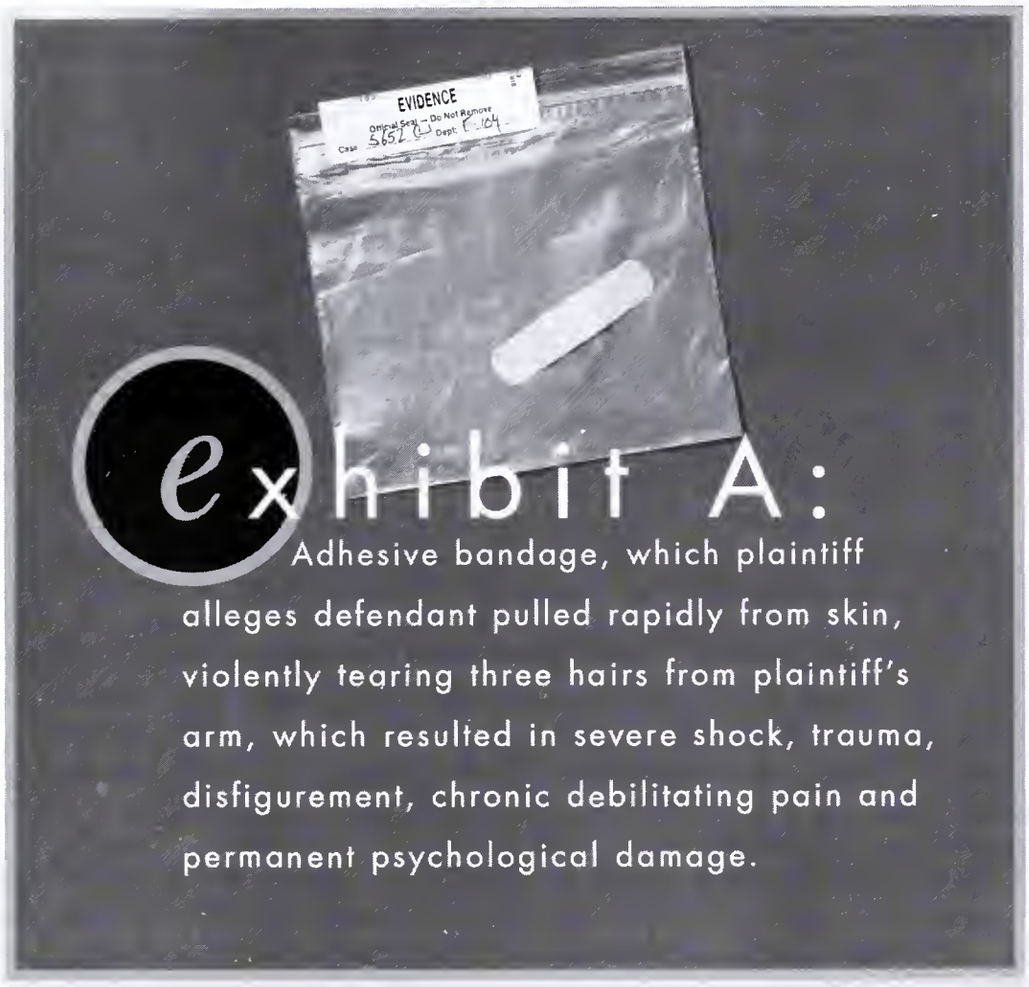

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People

Dallas plastic surgeon **Rod Rohrich, MD**, was named 1 of 20 notable North Dakotans by *The Bismarck Tribune.*

Houston obstetrician-gynecologist **Joe Leigh Simpson, MD,** was elected 1998–1999 president for the Society for Gynecologic Investigation.

Houston cardiovascular disease specialist **Richard W. Smalling, MD,** was named 1998–1999 president-elect of the board of directors for the American Heart Association, Texas Affiliate.

San Angelo internist **Dan Stultz, MD,** was named chief executive officer for Shannon Health System.

General practitioner **James Taylor, MD,** was honored for his years of service at Nacogdoches Memorial Hospital during the hospital's 70th birthday party.

The 1999 El Paso Society of Plastic Surgeons officers include **Bob Thering, MD,** president; **Manuel Feliberti, MD,** president-elect; and **William Miller, MD,** secretary-treasurer.

Charles N. Verheyden, MD, Temple, was selected as an American Board of Plastic Surgery examiner and appointed to the Residency Review Committee for Plastic Surgery, which is comprised of appointees from the American Medical Association, the American College of Surgeons, and the American Board of Plastic Surgery.

Deaths

Clifton Harold Beasley, MD, 82; Heber Springs, Ark; University of Arkansas for Medical Sciences College of Medicine, 1941; died January 5, 1999.

Simon Isadore Benavides, Jr, MD, 88; Raymondville; The University of Texas Medical Branch at Galveston, 1934; died December 16, 1998.

William Setzer Brumage, MD, 85; Austin; Baylor College of Medicine-Dallas, 1937; died December 29, 1998.

People

Houston Maurice Burk, MD, 78; Amarillo; The University of Texas Southwestern Medical School at Dallas, 1944; died December 15, 1998.

James Allen Chamberlin, MD, 87; Sugar Land; Tulane University School of Medicine, 1942; died December 30, 1998.

Caryn Keller Halpern, MD, 51; Dallas; State University of New York Health Science Center at Brooklyn College of Medicine, 1972; died December 18, 1998.

Jerome S. Kozak, MD, 76; Houston; Medical College of Wisconsin, 1953; died January 9, 1999.

Peter Max Marcuse, MD, 84; Houston; University of Basel Faculty of Medicine-Switzerland, 1938; died December 19, 1998.

William Harland Morgan, MD, 86; La Vernia; Temple University School of Medicine, 1941; died December 27, 1998.

Edwin Marvin Ory, MD, 79; Houston; Vanderbilt University School of Medicine, 1943; died January 10, 1999.

Thomas V. Patterson, MD, 80; Denton; The University of Texas Southwestern Medical School at Dallas, 1944; died December 27, 1998.

Lewis Eugene Pope, MD, 65; Arlington; Tulane University School of Medicine, 1958; died January 5, 1999.

Harry Stephen Smith, MD, 79; Houston; The University of Texas Southwestern Medical School at Dallas, 1944; died January 3, 1999.

David Shellenburger Stayer, MD, 90; Irving; Hahnemann University School of Medicine, 1936; died December 17, 1998.

Harold Vernon Towell, MD, 72; Kerrville; McGill University Faculty of Medicine-Quebec, 1951; died September 25, 1998.

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Former TMA director C. Lincoln Williston dies

Former Texas Medical Association executive director C. Lincoln Williston, whose leadership and organizational skills are credited with making TMA one of the top state medical societies in the nation, died February 1 in an Austin hospital. He was 78.

"Linc Williston's knowledge, expertise, and character provided a model for all medical society executives," said Louis J. Goodman, PhD, CAE, executive vice president of TMA.

Mr Williston came to TMA in 1954 from Chicago, where he was public information manager for the University of Illinois-Chicago Professional Colleges. He made the move to Austin with a pregnant wife and two small children, and immediately set about developing the association into an organization that effectively represents Texas physicians.

"He took a state medical association that really had no organizational structure and just through his sheer will of applying his time and his talent really put it all together," said Robert G. Mickey, retired TMA executive vice president who succeeded Mr Williston.

"He traveled the state extensively," Mr Mickey recalled. "Even the year before he retired he was still going to county medical societies and speaking. He felt very keenly about grassroots. TMA's success was the fact that the organization was able to bring people in from all over the state and be involved in the program. Not many state medical associations have been successful in that regard."

TMA membership more than tripled and a wide array of member services were expanded during Mr Williston's 33-year tenure. The association's library grew from fewer than 11,000 volumes and 395 journal subscriptions to more than 54,000 volumes and more than 1,000 journal subscriptions; the association's group insurance program was launched, and TMA became the first state medical society to devote staff resources to serving the needs of physician specialty societies. In addition, service to and representation of physician members on socioeconomic, legal, and legislative issues were made in-house functions.

"He took a state medical association that really had no organizational structure and just through his sheer will of applying his time and his talent really put it all together."

Known for his loyalty to TMA, his devotion to his family, his religious faith, his dedication to the Rotary Club, and his ardent love of golf, Mr Williston expressed his philosophy of success during an interview with *Texas Medicine* magazine when he retired in 1986. "I believe that if you are committed to service, and if you're willing to give the time and dedication, then you will be rewarded for your accomplishments," he said.

Mr Williston received the TMA Distinguished Service Award in 1986. In presenting the award, the TMA Board of Trustees and the Board of Councilors said that much "of the credit for the strength and vitality of the Texas Medical Association as it exists today, and for the respect and support it enjoys among Texas physicians may indeed be attributed to C. Lincoln Williston." Also in 1986, Mr Williston and Philip R. Overton, JD, TMA's former general counsel, shared the American Medical Association's Citation of a Layman for Distinguished Service Award.

A certified association executive, he was active in the Austin community. Among his civic activities were serving as chair of the Seton Medical Center Board of Advisors and vice president of the Austin Chamber of Commerce. He was a founding member of St Theresa's Catholic Church.

Mr Williston was a 1942 graduate of the University of Illinois School of Journalism, where he received the Sigma Delta Chi "Most Outstanding Graduate" award, and served as a US Army Air Corps captain during World War II. Based in Guam, he was responsible for premission briefings and postmission interrogations of B-29 bomber crews.

Survivors include his wife, Jane, three children, and seven grandchildren.

Mr Williston's family has offered several suggestions for memorial contributions, including the Texas Medical Association Foundation. ★

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Texas Medicine Rounds

By Johanna Franke

God is in the details

El Paso physician and best-selling author discusses medicine and writing

Abraham Verghese, MD, does not really see a big distinction between medicine and writing. Both are based on observation and on deciding what is significant. After all, what is a medical history but a story? "I heard the same aphorism in both medical school and writing school: God is in the details," said Dr Verghese, professor of medicine and chief of infectious diseases at Texas Tech University Health Sciences Center in El Paso. "I don't really see a dichotomy between the two, and I really feel that one informs the other. I couldn't imagine just being a writer without having this wonderful opportunity to observe what W. Somerset Maugham called 'humanity in the rough.' That's the substrate about which I write."

In his latest book *The Tennis Partner: A Doctor's Story of Friendship and Loss,* Dr Verghese tells the story of David Smith, MD, a medical student who came to America from Australia on a tennis scholarship and played briefly on the pro tour before deciding to become a physician. Dr Smith adopted Dr Verghese as his mentor in medicine at Texas Tech, but the roles were reversed when the two good friends hit the tennis court. This balance was broken when Dr Smith fell back into his old habits as an intravenous cocaine addict, which eventually led to his death.

TexMed '99 speaker
Abraham Verghese, MD

"I think writing the book helped me understand that David had a disease," said Dr Verghese, who will deliver the keynote presentation at the opening general session of TexMed '99 in Dallas. "But David was responsible for his disease. If you're a diabetic, it's not your fault, but you're responsible for servicing your diabetes — for checking your blood sugar and taking your insulin. No one knew more about David's disease than David, but he couldn't service it and he failed there."

In *The Tennis Partner,* Dr Verghese says he tried to show people how easily one can get caught up in an addict's life and become part of the addict's denial. The book also teaches that friendships are not just incidental, but vital, to our lives.

Dr Verghese traces his love for writing back to his childhood in Ethiopia, where his career-oriented, middle-class Indian family discouraged his interest in journalism and encouraged a future in medicine or law. "I had no misgivings about going into medicine," Dr Verghese said. "I thought it was very passionate and romantic, but I just kept feeling this sense that everything I saw was building up in me and was bottled up. I needed some form to express it and let it out, and that's how the writing started."

After completing his medical education in Ethiopia and India and working as an orderly in various US hospitals, Dr Verghese finished his internship and residency in Johnson City, Tenn, the setting for his first book, *My Own Country: A Doctor's Story.* He then completed his training in infectious diseases in Boston and returned to Johnson City in the late 1980s to practice his specialty. He became the town's AIDS expert as the modern-day plague made its way from the city to the country. Dr Verghese's AIDS patients often told him their biggest regrets were not having pursued their dreams. This inspired the future author's next move.

In 1990, Dr Verghese relocated to Iowa City, where he worked in a University of Iowa outpatient AIDS clinic and cashed in his retirement to attend the Iowa Writers' Workshop before moving his wife and two young sons to El Paso in 1991. The workshop's instructors encouraged Dr Verghese to turn his Johnson City experiences into *My Own Country,* which was named one of the five best books of 1994 by *Time* magazine and made into a Showtime movie last year. The book also has become required reading in several humanities programs at medical schools across the country.

Dr Verghese uses short stories in his own teachings to help medical students and residents express their feelings about their experiences working with patients. His teaching methods also emphasize important bedside skills that Dr Verghese believes are falling by the wayside in today's technological age.

"The great irony is the more technology we've developed, the less faith students and residents seem to have in their ability to extract clues from the body," Dr Verghese said. "Instead, they rely heavily on the technology. To me, the great adventure in medicine is the bedside diagnosis and the ability to confirm that with the necessary lab tests. This is an obsession of mine partly because I think that's how we keep the tradition of medicine alive instead of becoming technocrats and losing the art."

Physicians in developing countries have mastered physical diagnosis at the bedside because they have nothing but their eyes and hands to make a diagnosis, Dr Verghese says. He developed his bedside skills in India's British system of medicine and in Africa. "I tell my students that's the fun part of medicine, and it's the measure of their skill," he said. "Your worst nightmare as a student or a resident is that someone will pass through your hands with a diagnosable, treatable disease that you miss because your skills weren't as good as they should've been. By the time the patient is diagnosed by somebody else, it's no longer treatable or curable."

Besides his teachings, Dr Verghese says he also would like to pass along a novel to his students and the rest of the next generation of physicians. "I am convinced that one of the things that draws good people into medicine is often a novel. In America, that book is *Arrowsmith* by Sinclair Lewis. But for me it was Maugham's *Of Human Bondage.* There was something in that novel that made medicine seem passionate and terribly interesting."

"I just kept feeling this sense that everything I saw was building up in me and was bottled up. I needed some form to express it and let it out, and that's how the writing started."

Dr Verghese is already hard at work on this novel, which will take him into the fictional phase of his writing career. He also will continue his work at Texas Tech in El Paso, a city that has become "a very magical place" for him.

"I like the idea of a border city, in which we're in America but on the edge of America. And we're practicing medicine that's often Third World medicine," Dr Verghese said. "We're seeing diseases that you don't see anywhere else in America.

"I also like the idea of the border mythology. El Paso was once the land of the Pueblo Indians and the Spanish Conquistadors, and then came the Mexican Revolution and the Wild West. There's plenty of room in there for an African-born Indian to weave his own mythology," Dr Verghese said. "As a writer, there's something to that vast landscape that opens you up, inspires you, and gives you permission to think in big, sweeping terms."

Dr Verghese wraps up the opening general session at TexMed '99 with his presentation "Healing the Healer: The Balance Between Patient Care and Care of One's Self" on May 6 from 4 to 5 pm in the Wyndham Anatole Hotel's Stemmons Auditorium. ★

New TDI commissioner balances consumers, industry

If José Montemayor can ride herd on nuclear missiles, then regulating the Texas insurance industry should be no problem, even though both can be explosive. "I think nukes are pretty tame compared with the insurance companies," Mr Montemayor joked shortly after Gov George W. Bush appointed him as the state's new commissioner of insurance. He succeeds Elton Bomer, whom the governor named to be both secretary of state and a senior adviser.

"José Montemayor is a capable and experienced public servant," Governor Bush said in announcing his selection of Mr Montemayor, 47, who most recently was the associate commissioner of the Texas Department of Insurance (TDI). He said Mr Montemayor "understands insurance issues and will be fair and evenhanded as he balances the interests of industry and consumers."

Mr Montemayor was selected in early January to serve the remainder of Mr Bomer's term that ended February 1, and was then appointed to a full 2-year term. The appointment is subject to confirmation by the Texas Senate.

Born in Brownsville, Mr Montemayor worked his way up the ranks in the US Air Force, beginning as an enlisted man working on jet engines in 1969 and retiring as a major in 1993, when he joined TDI as director of insurance services. During his Air Force career, Mr Montemayor served as an intercontinental ballistic missile (ICBM) combat crew commander and handled logistics management for the Peacekeeper and Minuteman ICBM programs.

The new commissioner said his predecessor left behind a "superb legacy" and that he intends to "lead TDI in the same direction of efficient regulation that is fair to both consumers and insurers." Specifically, he says he is committed to continuing Mr Bomer's pledge to keep the quality of health care as high as possible and at the same time keeping costs reasonable. "I don't see that abating in the least."

One issue Mr Montemayor may have to deal with in the coming months is placing large capital reserve requirements on physician-directed health care networks. Some lawmakers and insurers have expressed interest in such requirements, which likely would eliminate many of them. (See "Legislating Health," January 1999 *Texas Medicine*, pp 29–33.)

"The reality is I have not given that a great deal of study," he said, adding, "Obviously if you're going to license somebody, you ought to have minimum capitalization requirements."

"I always welcome open dialogue with the industry as well as consumers. I see myself as continuing the dialogue."

TDI Commissioner José Montemayor

Mr Montemayor admits he has "a tough act to follow" in succeeding Mr Bomer, who established a reputation as an activist commissioner who made TDI more receptive and responsive to complaints from physicians about what they considered to be unfair or inappropriate practices by insurance companies. In one memorable incident in early 1997, Mr Bomer drove to the Austin offices of PCA Health Plans of Texas to personally persuade surprised company officials to drop their plans to limit PCA members' access to allergy medication. Would Mr Montemayor consider taking similar action if circumstances warrant?

"I always welcome open dialogue with the industry as well as consumers," he replied. "I see myself as continuing the dialogue. To the extent that there are honest problems out there, I don't hesitate at all to pick up the phone and invite a management team in for a conference and explain what I perceive to be the issues and ask them to offer me their solutions. I'll either be able to live with their solutions or I'll ask them to go back to the drawing board or I'll suggest my own. I am not at all shy about that. I do a great deal of that in my current capacity and I don't anticipate that changing very much."

A certified public accountant, Mr Montemayor earned a bachelor of science degree from St Edward's University, a master of business administration in finance and banking from the University of North Dakota, and a master of arts in administration from Webster College. He also holds a master's degree in accounting from Southwest Texas State University and was a fellow at the Kellogg Foundation.

He and his wife, Dolores, have three children and two grandchildren. ★

MedBytes

March's "MedBytes" helps you prepare for on-site office inspections and register for TexMed '99 using Texas Medical Association resources.

Surfing the Web for initial inspection info?

Most health maintenance organizations (HMOs) are striving to achieve accreditation by the National Committee for Quality Assurance (NCQA). To meet these standards, physicians attempting to contract with an HMO must undergo an on-site office inspection as part of the initial credentialing process and every 2 years thereafter for recredentialing. For an online self-assessment checklist to prepare your practice for such a review, go to the "Business of Medicine" section of TMA's Web site at www.texmed.org and select "Quality Improvement." The NCQA site at www.ncqa.org also can help with inspection preparation and includes information for providers, health care organizations, researchers, employers, and consumers.

TECAP talk

Developed through TMA's Medical Directors' Forum, the Texas Environment of Care Assessment Program (TECAP) will circumvent multiple inspections for physicians who sign contracts with multiple health plans while still complying with NCQA credentialing standards. (See "It Just Makes Sense," pp 34-37.) As a unified, statewide office inspection tool, TECAP will allow office site survey and medical record review information to be gathered using a single protocol. This information will be shared among all participating health plans. For more information or a schedule of TECAP rollout dates, go to tecap.texmed.org.

Your Internet line to TexMed '99

Type in virtual.texmed.org to find the official online source for all your TexMed '99 needs. This site will help you prepare for TMA's annual meeting, May 6–9, at the Wyndham Anatole Hotel in Dallas, by allowing you to:

- Register online for the meeting and special events.
- Visit the virtual exhibit hall and search for specific products, services, vendors, and booth locations.
- Review the House of Delegates and reference committee meeting schedules.
- Become familiar with the general session speakers through their online biographies.
- Obtain hotel and travel information.
- Get all the details on TexMed's special family activities, child care, and sports events.
- Make dinner reservations in Dallas through SavvyDiner.com.
- Get maps and directions to the Wyndham Anatole Hotel in Dallas.

Cyber Sweepstakes gets spring fever

Be sure to drop by the TMA Web site at www.texmed.org before March 31 to sign up for TMA's spring Cyber Sweepstakes. TMA members who provide or confirm their e-mail addresses through the "Members Only" section before the end of March are automatically entered to win a Diamond Rio PMP300 player. The portable player stores music files on a computer in such a way that the file size is relatively small, but the music maintains CD-quality sound. Your e-mail address will be used to contact you with breaking health care news.

MedBytes is a quick look at new, or newly discovered, Web sites of interest to Texas physicians. The column also highlights features of the TMA Web site at www.texmed.org. If you know of some cool medical sites or have questions about how to use the TMA Web site, e-mail johanna_f@texmed.org. Publication of information about Web sites in this column is not to be considered an endorsement or approval by the Texas Medical Association of the sites or sponsors, or of any products or services involved.

TexMed'99

TexMed '99 offers education, recreation

New educational tracks, stellar speakers, and plenty of family activities highlight Texas Medical Association's TexMed '99: Educational Showcase & Expo, Thursday through Sunday, May 6–9, at the Wyndham Anatole Hotel in Dallas.

TMA's annual meeting has evolved to meet your needs with more than 200 hours of continuing medical education (CME) including topics from specialty sections and six general educational tracks. Track topics include ethics of end-of-life care, the clinical practice of medicine, computers and technological advances in medicine, the science of alternative/complementary practices, the business aspects of the practice of medicine, and socioeconomics. CME opportunities are free to TMA members. You also can fulfill CME requirements through the TMA Library's CME on Demand Center. The center, open May 6–8, comes complete with a reference librarian; independent study carrels with computers, VCR/TV combinations, and audiocassette players; and plenty of CME materials to check out.

You can fulfill your medical ethics CME requirement by using CME on Demand Center resources, participating in the 16-hour end-of-life care general educational track, or attending the opening general session on May 6 from 2 to 5 pm in the Wyndham Anatole Hotel's Stemmons Auditorium. In her general session presentation "Addressing the Challenges of Privacy and Confidentiality in the 21st Century," Ellen Wright Clayton, MD, JD, will discuss the ethical issues surrounding the disclosure of genetic information to family members. Dr Clayton, an associate professor of pediatrics at Vanderbilt University School of Medicine in Nashville and an associate professor of law at Vanderbilt University School of Law, has been active in debates on access to genetic information and research.

Helen Hobbs, MD, professor of internal medicine and molecular genetics at The University of Texas Southwestern Medical School at Dallas, also will speak at TexMed's opening general session. Dr Hobbs, who is chief of UT Southwestern's Division of Medical Genetics and was instrumental in creating UT's Center for Human Genetics, will present a program titled "How Genetics Will Influence the Practice of Medicine in the 21st Century." Best-selling author and keynote speaker Abraham Verghese, MD, rounds out the presentations at the opening general session, which is underwritten by the Texas Medical Liability Trust. In "Healing the Healer: The Balance Between Patient Care and Care of One's Self," Dr Verghese, chief of infectious diseases at Texas Tech University Health Sciences Center in El Paso, will tell the tragic story of a colleague's battle with addiction using experiences

Texas Medical Association's TexMed '99: Educational Showcase & Expo, Thursday through Sunday, May 6–9, at the Wyndham Anatole Hotel in Dallas

Win big with the TexMed '99 Member Roundup

Texas county medical societies have a chance to win a computer or digital camera for their offices simply by increasing their numbers at Texas Medical Association's annual meeting, TexMed '99: Educational Showcase & Expo, May 6–9 at the Wyndham Anatole Hotel in Dallas.

To win a TexMed '99 Member Roundup prize, county medical societies must create the best TexMed '99 promotion pieces using any of the following communication vehicles: magazine articles or ads, newsletter articles or ads, special mailings or faxes to members, and other promotional pieces such as reminder cards and posters in physician lounges.

The TexMed '99 Member Roundup has a special category for the host society, Dallas County Medical Society (CMS). By increasing attendance by 10% over the last TMA annual meeting in "Big D," Dallas CMS could win a computer or digital camera.

For the purposes of this contest, only physician and resident TMA members can be counted in attendance numbers — not medical students. Promotional materials created or used by participating county medical societies must by submitted by May 1 to Paula Rigling, TMA Conference and Meeting Management, 401 W 15th St, Austin, TX 78701. Winners will be announced in late May. For more information on the TexMed '99 Member Roundup, contact Ms Rigling at (800) 880-1300, ext 1450, or (512) 370-1450; or e-mail paula_r@texmed.org.

from his book *The Tennis Partner.* (See "God Is in the Details," pp 16-17.)

Immediately following the opening general session, join other TMA members in a tribute to the late San Antonio psychiatrist Victor J. Weiss, Jr, MD. Before his death in 1997, Dr Weiss, a member of the TMA Board of Trustees, planned to commission a three-dimensional work of art for the foyer of the TMA building. Dr Weiss' widow, Belinda, realized that promise with a Garland Weeks sculpture that will be unveiled at the close of the May 6 general session. A special "Meet the Speaker" reception and book signing in Atrium 1 following the unveiling will give you a chance to talk with general session speakers and celebrate Texas Medical Liability Trust's 20th anniversary.

TMA has pulled together so many powerful speakers this year that a second general session, on May 8 from 8 to 9 am in the Wyndham Anatole Hotel's Stemmons Auditorium, was added to the TexMed '99 lineup. Wayne Sotile, PhD, and his wife, Mary Sotile, MD, of Winston-Salem, NC, will discuss physician marriages and relationships with colleagues in their presentation "Where Are the Heroes? Keeping the Flame Alive at Home and Work!" (See "Living with 'Success Stress,'" pp 50-52.) The Sotiles will be available following their program to visit and sign copies of their books on medical marriages.

The TMA House of Delegates will meet May 6 in Stemmons Auditorium and May 7 in Khmer Pavilion, both lo-

Tee off for Texans' health at TMAF golf tournament

TMA Foundation's C. Lincoln Williston Golf Tournament presents the perfect opportunity to improve the state's public health and play an exciting game of golf. The tournament, being held Wednesday, May 5, at Riverchase Golf Course in Coppell, which is just outside of Dallas, is held in conjunction with TexMed '99 and will raise money for Foundation programs that address Texans' health concerns.

The tournament will again feature the shortgame format, which is taken from Harvey Penick's *Little Red Book* and is based on his philosophy that good scoring in golf originates from mastery of the shortgame. Eighteen shortgame shots starting no farther than 100 yards from the hole will be selected for the event, and players can participate in on-course contests for different shots. Riverchase golf pro Bob Archer will host a clinic to help you warm up before the tournament begins. Afterwards, stay for dinner and the awards ceremony.

The entry fee is $125, which gives you 18 holes of golf with a cart, an official tournament golf item, the shortgame clinic, on-course contests, complimentary nonalcoholic beverages on the course, a meal at the awards dinner, team photos for each player, and use of the practice range and putting green.

You don't have to be an expert to participate, and this competitive, nonhandicapped golf tournament allows men and women to compete on a level playing field while supporting a good cause. Play is conducted in two-person teams, so select your own partner or leave it to us!

Don't bogey this opportunity to improve the health of all Texans. Advance registration is required for the tournament. Registration deadline is April 14. For more information or to register, call Heather Summers at (800) 880-1300, ext 1466, or (512) 370-1466; or e-mail heather_s@texmed.org.

Alliance activities celebrate the family of medicine

TEXAS MEDICAL ASSOCIATION ALLIANCE

Have a big time in "Big D" at Texas Medical Association Alliance's 81st annual convention to be held in conjunction with TexMed '99 this May at the Wyndham Anatole Hotel.

To commemorate the alliance's partnership with medicine, the alliance has arranged an evening for physicians and their families at the Dallas World Aquarium on Thursday, May 6, from 6:30 to 10 pm. After enjoying a fine dinner in casual, comfortable attire, listen to words of wisdom from Texas' own Ross Perot, a strong advocate of putting patients first. Your children will enjoy a special dinner and activities of their own at the aquarium while you hear Mr Perot's views on medicine.

Alliance members specifically are requested to attend TexMed '99 events, including alliance President Mary Ann Homer's report to the TMA House of Delegates on Thursday morning, May 6, and TexMed's general sessions on Thursday afternoon and Saturday morning, May 8.

The joint installation luncheon at the Wyndham Anatole Hotel's Chantilly Ballroom West on Friday, May 7, honors incoming TMA President Alan C. Baum, MD, Houston, and incoming TMA Alliance President Pam Hendricks, Temple.

Other alliance activities include a tour of homes and a dinner on historic Swiss Avenue, a communication tune-up, InfoExpo courses, and programs on membership, managed care, and stress management. For more information on alliance events, contact Leslie Tate at (800) 880-1300, ext 1328, or (512) 370-1328; or e-mail leslie_t@texmed.org.

TexMed'99

cated in the Wyndham Anatole Hotel, to consider resolutions from county medical societies and reports from TMA boards, councils, committees, and sections. During a break in House action on May 7, Houston ophthalmologist Alan C. Baum, MD, and Pam Hendricks, of Temple, will be honored as the next presidents of TMA and TMA Alliance at the joint presidents' installation luncheon from noon to 1:30 pm in the Wyndham Anatole Hotel's Chantilly Ballroom West. The luncheon, underwritten by TIAA-CREF and the Texas Medical Association Insurance Trust, requires advance purchase of tickets, which are $15.

After completing your business, consider participating in some of TexMed's special events. The entertainment calendar kicks off May 5 with the C. Lincoln Williston Golf Tournament benefiting the TMA Foundation. (See "Tee Off for Texans' Health at TMAF Golf Tournament," p 21.) On May 6, attend one of several dinner and reception options including the TMA Alliance's Dallas World Aquarium Dinner, featuring speaker Ross Perot and a special dinner and activities for children, from 6:30 to 10 pm. Or, visit with those running for elected TMA offices at a "Meet the Candidates" reception hosted by county medical societies from 6 to 7:30 pm at the Wyndham Anatole Hotel. The Fifty Year Club will gather for its annual reception and dinner meeting from 6 to 10 pm at the Wyndham Anatole Hotel, and the Oenological Society will meet for dinner and wine tasting at 7:30 pm in Nana's Grill, also at the Wyndham Anatole Hotel.

On May 7, grab your family and hop on a shuttle to Six Flags Over Texas, Johnnie High's Country Music Review, or Trail Dust Steak House in Arlington. Free shuttles to those destinations as well as Dallas' West End and Deep Ellum will run from 6 to 11 pm from the Wyndham Anatole Hotel. You also can get into a New York state of mind by attending the TMA Foundation's benefit "New York Nights" from 6 to 11 pm at the Wyndham Anatole Hotel. (See "Have a Swingin' New York Night at TMAF Benefit" on this page.)

TexMed's Culture Bus Tour will take your family and you to Fort Worth's Cultural District on May 8. With nationally recognized museums such as the Kimbell Art Museum, the Amon Carter Museum of Western Art, and the Modern Art Museum of Fort Worth, as well as the 110-acre Botanical Gardens and Conservatory, the cultural district has something for everyone. Follow up your museum visits with the restaurants and shopping of Sundance Square. The TexMed '99 culture bus will make continuous trips between Fort Worth's Cultural District, Sundance Square, and the Wyndham Anatole Hotel from 9 am to 4 pm on May 8.

For those of you looking for fun outdoor activities, TexMed offers a limited number of participants a trip to the Heard Natural Science Museum and Wildlife Sanctuary on May 8. Visit the museum and hike the 5-mile nature walk at the wildlife sanctuary, which features 287 acres with more than 240 species of birds, mammals, reptiles, and amphibians, and nearly 150 species of wildflowers. The bus departs the Wyndham Anatole Hotel for the sanctuary trip, which comes complete with boxed picnic lunches, at 8:30 am and returns at 2 pm. Or, you could participate in a lively game of tennis at the Wyndham Anatole Hotel's Verandah Club from 3 to 5 pm on May 8.

Kids Konventions of Texas will provide on-site child care again at this year's meeting. To register for TexMed '99 and reserve your place for these special activities, check out your TexMed '99 program or consult the TexMed '99 Web site at virtual.texmed.org. (See "MedBytes," p 19.) For more information, contact Paula Rigling at (800) 880-1300, ext 1450, or (512) 370-1450; or e-mail paula_r@texmed.org. ★

Have a swingin' New York night at TMAF benefit

Imagine the thrill of an evening in Manhattan's most fashionable nightclub at "New York Nights," TMA Foundation's sixth annual benefit from 6 to 11 pm on Friday, May 7, at the Wyndham Anatole Hotel during TexMed '99 in Dallas. Proceeds from the benefit support the Foundation's mission to fund programs that improve the health of all Texans.

This year's setting gets you in the mood for swing dance lessons from Dallas' DanceMasters as well as the Big Band, Tin Pan Alley, and Sinatra sounds of Larry "T-Byrd" Gordon and The Music People Luv Band. T-Byrd Gordon, who plays 27 instruments and has a doctorate degree in music, has shared the stage with the likes of James Brown, Tony Bennett, and Chuck Berry, and has performed for the royal family Rainier of Monaco and for stars such as Debbie Reynolds, Neil Simon, and Eva Gabor.

You'll also enjoy dinner, a silent auction, and a martini bar (but no cigars, please!). Regular tickets are $100 each, but for $125, you'll be recognized as a New York City sponsor in the event program and TMA Foundation newsletter.

For more information or to obtain tickets for the benefit, call Heather Summers at (800) 880-1300, ext 1466, or (512) 370-1466; or e-mail heather_s@texmed.org.

TexMed '99 at a glance

WEDNESDAY – May 5

Sports Events
C. Lincoln Williston Golf Tournament

THURSDAY – May 6

8–9:30 am
House of Delegates Opening Session

8 am–5 pm
Texas Academy of Family Physicians — Add a Day to TMA

10 am–1:30 pm
Reference Committees

Scientific Sections
Digestive Diseases (9 am–noon)

Symposia
Emergency Medicine (9 am–1 pm)

2–5 pm
General Session (Underwritten by Texas Medical Liability Trust)

5–6 pm
Meet the Speakers Reception/Book Signing

After 6 pm
CMS Meet the Candidates Reception
Alliance Dallas World Aquarium Dinner with Ross Perot
Alumni Events
Nightlife Shuttle

FRIDAY – May 7

7:30 am–5:30 pm
Exhibits

9 am–noon; 1:30–4 pm
House of Delegates

9–10:30 am
Mercer Investment Seminar

Educational Tracks (NEW!)
The Business Aspects of Medical Practice (9 am–5 pm)
Ethics EPEC End-of-Life Care (7:30 am–5:30 pm)
Technological Advances in Medicine (2–5 pm)

8 am–5 pm
Sections
Endocrinology (8 am–12:30 pm)
Family Practice (9 am–5 pm)
Neurological Surgery
Obstetrics and Gynecology (2–5 pm)
Occupational Medicine
Ophthalmology
Otolaryngology (9 am–5 pm)
Plastic, Reconstructive, and Maxillofacial Surgery (8 am–4:30 pm)
Psychiatry (9 am–5 pm)
Public Health (8 am–4:15 pm)
Surgery

8 am–5 pm
Symposia
Blood and Tissue Usage (2–5 pm)
Diabetes (2–5 pm)
Prevention of Societal Violence (2–5 pm)
Sports Medicine

8 am–5 pm
Specialty Societies
Texas Dermatological Society (2–5 pm)
Texas Orthopaedic Association

Noon–1:30 pm
TMA/TMAA Presidents' Installation Luncheon

2–3:30 pm
Mercer Investment Seminar

6–11 pm
TMA Foundation Benefit — "New York Nights"

After 6 pm
Alumni Events
Specialty Society Functions
Family Night Out Shuttle
Nightlife Shuttle

SATURDAY – May 8

Sports Events
Tennis (3–5 pm)

7:30 am–4 pm
Exhibits

8–9 am
General Session

8:30 am–2 pm
Heard Natural Science Museum and Wildlife Sanctuary

9 am–4 pm
Culture Bus Tour

9 am–5 pm
Educational Tracks
The Clinical Practice of Medicine
Computers in Medicine
Ethics EPEC End-of-Life Care
The Science of Alternative/Complementary Practices (9 am–5 pm)
Socioeconomics

9 am–5 pm
Specialty Societies
Texas Dermatological Society (8:30 am–noon)
Texas Orthopaedic Association (8 am–5 pm)
Texas Society of Anesthesiologists (7:55 am–4:15 pm)

9 am–5 pm
Scientific Sections
Allergy, Asthma, and Clinical Immunology (7 am–5 pm)
Colon and Rectal Surgery (9 am–12:30 pm)
Neurological Surgery (8 am–5 pm)
Ophthalmology
Otolaryngology (8:30 am–noon)
Pediatrics (9 am–12:10 pm)
Physical Medicine and Rehabilitation

9 am–5 pm
Symposia
Adolescent Risk Assessment (9 am–noon)
Cancer: What Primary Care Physicians Need to Know
Diabetes (9 am–noon)
Heart Care Partnership (8 am–noon)
Pain (9 am–noon)
Sleep Disorders (8 am–noon)

House of Delegates Sections
Organized Medical Staff
Medical Student
Resident Physician
Young Physician

After 6 pm
Alumni Events
Specialty Society Functions

SUNDAY – May 9

EPEC Train-the-Trainer Workshop (8 am–noon)
Texas Dermatological Society (8:30 am–noon)

Family practitioner John Weaver, MD, left, consults with patient Eben Gourley, center, outside Dr Weaver's Blanco office as receptionist Karen Cox looks on.

Dr Weaver's office complies with Americans with Disabilities Act guidelines and has ramps and special parking spaces for patients who have disabilities.

Does your office comply with ADA guidelines?

More than 3.5 million Texans have some form of disability. Though that's justification enough for physicians to make sure their offices are compliant with the Americans with Disabilities Act (ADA) of 1990, Blanco family practitioner John Weaver, MD, offers another reason: "It's the law!"

Dr Weaver was fortunate in that his office already followed some ADA guidelines when the law went into effect, such as handrails in the bathroom for safety and 4-foot-wide hallways. Patients with disabilities can easily access his office building, which has no stairs, from designated parking spaces right out front. In 1997, Dr Weaver took further steps to become ADA compliant by enlarging the bathroom, installing raised toilets, and making sure patients in wheelchairs had 5-foot-radius turnarounds inside his building.

Physicians designing new offices will find ADA guidelines built into today's construction codes, but those remodeling old buildings should make sure their offices are ADA compliant or suffer the consequences down the line when they're reported by patients or visited by inspectors, Dr Weaver says.

"If you don't comply, and you've got new construction that's almost done, they'll make you fix it," Dr Weaver said. "It's more economical in the long run to go ahead and follow the guidelines the first time rather than having to change your office later."

To help you better comply with ADA specifications, the Texas Medical Association Committee on Rehabilitation has produced a special insert that appears in this issue of *Texas Medicine* between pp 56 and 57. ★

A champion for people with disabilities

Lex Frieden, a civil rights advocate and leader of the independent living movement by people with disabilities, received the 1998 Henry B. Betts Award, a $50,000 unrestricted cash prize, for his instrumental role in implementing the Americans with Disabilities Act (ADA) in 1990. Mr Frieden, whose neck was broken and spinal cord severely injured in a car accident during his freshman year of college, is senior vice president for The Institute for Rehabilitation and Research (TIRR) in Houston and is the founder and director of TIRR's Independent Living Research Utilization program. He was nominated for the award by former US President George Bush, who said, "Since his injury in 1967, Lex has dedicated his life to improving the lives of all people with disabilities. I was proud to sign the ADA into law when I was president, and I am proud to have nominated Lex for this award."

Good Physicians Base Their Decisions on Facts.

Frontier Only Deals with the Facts

A recent article in Texas Medicine advised physicians to ask some very pointed questions prior to selecting a professional liability insurance provider. We could not agree more. Choosing the broadest coverage, from a financially stable, licensed and admitted insurance provider protects you and your future.

FACT #1: Frontier has been providing medical professional liability insurance for more than 20 years and is a licensed and admitted insurance company in the State of Texas. **FACT #2:** Frontier's financial stability is clearly demonstrated by our Standard and Poor's Rating of A+ (Excellent) and our A.M. Best Rating of A- (Excellent.) Our record of stability, flexibility and service has earned us the trust of more than 16,000 physicians and surgeons nationwide.

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SUMMARIES OF RECENT HEALTH CARE HEADLINES

In Case You Missed It

By Melissa McEver

Migraine-prone young women may be at a higher risk for ischemic stroke, researchers have discovered. Scientists from IMPERIAL COLLEGE SCHOOL OF MEDICINE and the RADCLIFFE INFIRMARY studied 291 women, ages 20–44, who had suffered a stroke, and found that between 20% and 40% of the strokes in women with a history of migraines seemed to occur directly from a migraine attack and that a family history of migraine increased both ischemic stroke risk and hemorrhagic stroke risk.
(*British Medical Journal*, 1/2/99)

The development of a possible genetic cure for hemophilia may usher in a new era for genetic therapy. Researchers from the CHILDREN'S HOSPITAL OF PHILADELPHIA, STANFORD UNIVERSITY SCHOOL OF MEDICINE, and CELLGENESYS INC in Foster City, Calif, working independently, discovered the effectiveness of a one-treatment genetic therapy for hemophilia B. Human trials have yet to be done, but the results are promising, the scientists said, and could prove that some diseases indeed can be cured by genetic therapy.
(*Nature Medicine*, 1/99)

Air pollution is a fact of life, but scientists concluded in three new studies that it is endangering our health. Dr Diane Gold of BRIGHAM AND WOMEN'S HOSPITAL in Boston, along with other researchers, reported that exposure to certain types of air pollution and ozone reduced lung function among 40 Mexico City schoolchildren. Dr Joel Schwartz of the HARVARD SCHOOL OF PUBLIC HEALTH compared hospital admission records with air pollution data and found associations between the numbers of admissions for cardiovascular problems in the elderly and the amounts of carbon monoxide and other matter in the air. Dr Lianne Sheppard and colleagues at the UNIVERSITY OF WASHINGTON in Seattle concluded after examining more than 14,000 hospital admissions that asthma attacks are associated with air pollution exposure.
(*Epidemiology*, 1/99)

Researchers have discovered a mutated gene that may play a role in 45% of lymphomas and in several other types of cancers, such as colon and testicular cancer and leukemia. Scientists at the INSTITUTE OF CANCER RESEARCH in London found these mutations in all testicular cancer cell lines tested, 2 of 25 colon cancers, and 2 of 18 leukemias. This gene is only the second implicated in such a large number of cancers.
(*Cell*, 1/8/99)

Baylor institute funded by $25 million grant

A new institute at Baylor College of Medicine will give insight into brain function and behavior, thanks to a 5-year $25-million grant from The Brown Foundation, Inc.

The institute will unite clinical and basic science researchers in studies of the biological basis of mental illness. Proposed areas of the institute's research include psychotic disorders, addictive behaviors, mood disorders, manic depression and anxiety, and learning and memory disorders. ★

TMA paper promotes elder abuse awareness

Texas Medical Association's Blue Ribbon Panel on Family Violence has completed "Elder Abuse and Maltreatment," the third paper in the panel's family violence series.

The paper, which is intended to raise awareness of the problem and educate physicians on how to identify and treat elderly victims of domestic violence, includes case studies on abuse, neglect, exploitation, and intervention. "Elder Abuse and Maltreatment" also outlines characteristics of caregivers who become perpetrators of elder abuse and signs of abuse to look for during a geriatric assessment. The paper's primary author, Carmel Bitondo Dyer, MD, is director of the Harris County Hospital District's geriatrics program and an assistant professor of medicine at Baylor College of Medicine in Houston.

Three different English and Spanish versions of an elder abuse poster and a copy of the paper will be mailed to approximately 10,000 family practitioners, general practitioners, internists, and emergency medicine specialists in Texas early this month. Physicians outside of these specialties can obtain the paper and posters by calling Megan Haley at (800) 880-1300, ext 1464, or (512) 370-1464; or by e-mailing her at megan_h@texmed.org. This project was funded by the Texas Medical Association Foundation. ★

Exhibit reviews history of drug regulation

The US Food and Drug Administration (FDA) takes center stage in a new exhibit on display through June 26 in the Texas Medical Association History of Medicine Gallery.

The FDA, the oldest federal agency dedicated to consumer protection, oversees items accounting for 25 cents of every dollar spent by US consumers. "FDA: The History of Drug Regulation" will cover the evolution of the current drug regulatory system recognized globally as the gold standard for drug safety and efficacy.

The gallery is located in the first-floor lobby of the TMA building at 401 W 15th St in Austin. The exhibit can be viewed from 8:15 am to 7 pm, Monday through Friday, and 9 am to 1 pm on Saturday. The TMA building is closed on major holidays. For information, contact Patty Mullins, special collections coordinator, in the TMA Library at (800) 880-1300, ext 1552, or (512) 370-1552; or e-mail patty_m@texmed.org. ★

Program gives Dallas infants healthy starts

Infant mortality rates in targeted areas of Dallas have decreased more than 50% since 1990, according to Dallas Healthy Start of Parkland Health & Hospital System.

The Texas Bureau of Vital Statistics reports that infant mortality rates dropped to 6.7 deaths per 1,000 births in 1996 from 14.5 infant deaths per 1,000 births in 1990 in south, central, and west Dallas. The drop has been attributed to programs established by Dallas Healthy Start and its more than 40 collaborative partners such as the Mom-Mobile service, which provided free transportation to more than 6,000 women and children in 1997 to get the medical attention they needed.

"We targeted our efforts to the issues that most affected people in identified pockets of need and tailored our programs, such as transportation and community outreach, to help them and their families," said Liz Cowles, director of Dallas Healthy Start. ★

Houstonians battle pediatric AIDS in Mexico

A team of AIDS experts from Baylor College of Medicine and Texas Children's Hospital in Houston have collaborated with the Bristol-Myers Squibb Foundation and Project HOPE to prevent the spread of AIDS and improve treatment for the disease south of the border.

The disease management program, called "A Helping Hand to the Little Ones," works to develop community outreach and education targeting pregnant women and women of childbearing age; to promote medical training of pediatricians, infectious disease specialists, and nurses who treat children with HIV or AIDS; and to secure donations of antiretroviral drugs for 200 pediatric AIDS patients and infant formula for 100 infants.

The team will receive $405,000 from the Bristol-Myers Squibb Foundation over 3 years to train Mexican physicians in pediatric HIV, and will conduct pediatric nursing symposia at key sites throughout Mexico. ★

Physicians unprepared for diabetic doubling

A survey conducted by NOP Healthcare, an independent market research agency, says that one third of physicians in nine countries consider themselves "more unprepared than prepared" for the demands of the worldwide diabetes epidemic. The World Health Organization predicts that the number of people with diabetes mellitus will double to 260 million by the year 2025, according to a November 1998 Reuters Health report.

NOP Healthcare contacted 111 patients with diabetes and 114 physicians who treat diabetes. Only 11% of physicians consider the medical profession fully prepared for the increased incidence of diabetes.

More than 20% of physicians said that the cardiovascular health of diabetic patients had improved over the past 10 years, while 60% said that cardiovascular health had improved "somewhat" in their diabetic patients. ★

BEFORE YOU SIGN

Contract TIPS

Things you need to know

Austin attorney/mediator Andre Hampton, JD, and the TMA Office of the General Counsel suggest an ideal managed care contract should:

- **Sufficiently identify the party or parties responsible for payment so that you can investigate their financial strength, client base, and reputation to determine that the arrangement will be beneficial for you and your patients.**
- **Not only require payment of your fees within a specified number of days — eg, 30 days — but also provide meaningful incentives for the payer's compliance with this requirement.**
- **Allow you reasonable time to submit completed bills and permit you to submit bills after the designated time when extra time is needed because of circumstances beyond your control.**
- **Require the payer to pay you for services rendered pursuant to a mistaken verification if the mistake did not result from your failure to follow the verification procedures provided by the managed care organization.**

Source: TMA's Texas Physician Services Organization (TPSO). For more information about TPSO services or to request a copy of the TPSO catalog, call (800) 523-TPSO or (512) 370-1418; or e-mail tpso@texmed.org.

CONNECT TO TMA

HotLines

TMA switchboard (800) 880-1300

Impaired physicians (800) 880-1640
Call this 24-hour hotline to report information concerning physicians who may be abusing alcohol or other drugs, or who may be chemically addicted, psychiatrically impaired, or have other problems. All calls are confidential.

Insurance (800) 880-8181
The Texas Medical Association Insurance Trust offers life, health, disability, office overhead, personal accident, and other insurance plans and products to TMA members, their families, and office staffs.

Loans (800) 880-2828
TMA offers qualified medical students and residents low-interest loans. Call for general requirements and application procedures.

TEXPAC (800) 880-1300, ext 1362
The TMA Political Action Committee speaks on behalf of physicians through grassroots involvement, personal relationships with elected officials, and political campaign participation and contributions.

TPSO (800) 523-8776
The Texas Physician Services Organization delivers physicians and physician organizations an array of products and services to help them succeed in the changing medical marketplace.

Use the following prefixes plus @texmed.org to e-mail for TMA resources.

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Medical Education	meded
Member Services	memberservices
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Physician Oncology Education Program	poep
Sneak Preview	sneakpreview
Specialty Societies	ssms
TMA Alliance	tmaa
TMA Bookstore	bookstore
TMA Library	tma_library
Texas Physician Services Organization	tpso

UT Southwestern creates transplantation program

A bone marrow transplantation program newly established at The University of Texas Southwestern Medical Center at Dallas is expected to provide potentially life-saving therapies to patients with cancers such as leukemia, lymphoma, and aplastic anemia.

The program, headed by hematology-oncology specialist Robert Collins, MD, who came to UT Southwestern from Baylor University Medical Center in Dallas, will introduce basic research into the clinical arena of bone marrow transplantation, which will help bring the latest technology in this field to patients. ★

UNT focuses on cancer research

Cancer has become the fifth biomedical research priority behind aging, heart disease, harmful substances, and human vision at the University of North Texas Health Science Center's Institutes for Discovery in Fort Worth.

With the creation of the Institute for Cancer Research, university researchers will study how cancer spreads in the human body to devise ways to prevent and treat metastasis. When fully operational, the institute will identify additional areas of cancer research, serve to translate laboratory findings into clinical studies among patients, and contribute to new approaches for cancer prevention, diagnosis, and treatment. ★

Texan receives inaugural APHA director citation

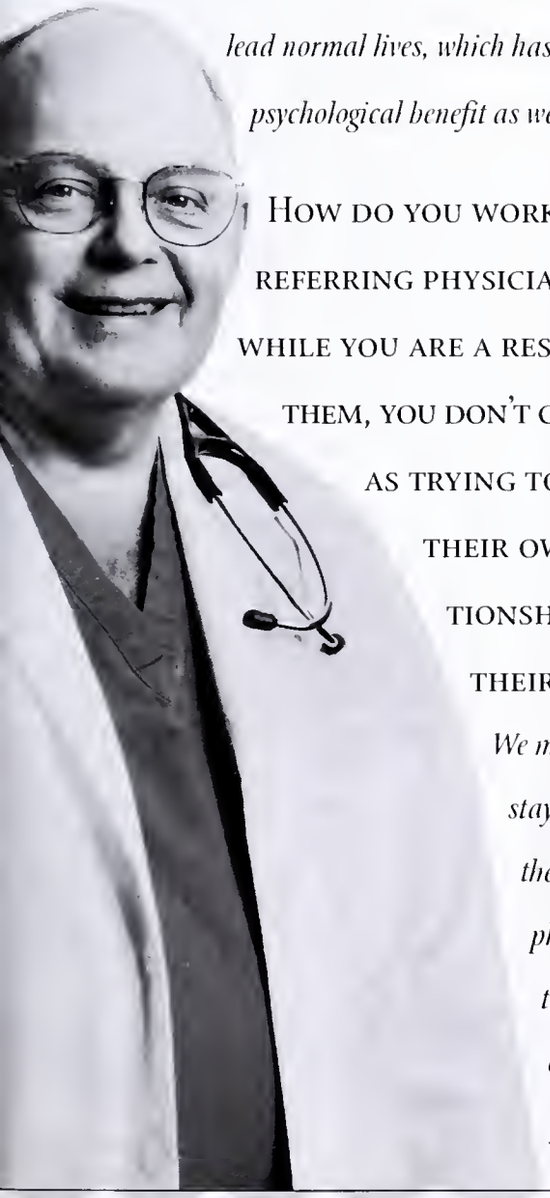
Fernando M. Treviño, PhD, MPH, received the American Public Health Association's first Executive Director Citation for his distinguished service as executive director from 1993 to 1996. Dr Treviño chairs the Department of Public Health and Preventive Medicine at the University of North Texas Health Science Center in Fort Worth. ★

Making A World Of Difference For The Referring Physician: Cook Children's Talks With Dr. Paul Gillette.

DR. PAUL GILLETTE — MEDICAL DIRECTOR OF PEDIATRIC CARDIOLOGY

. GILLETTE, YOU PIONEERED RADIO FREQUENCY LATION. IT'S WELL KNOWN THAT PATIENTS COME OM AROUND THE COUNTRY AND ALL OVER THE RLD FOR YOUR EXPERTISE. HOW DOES THIS OCEDURE HELP KIDS?

io frequency ablation allows us to treat children with serious liac arrhythmia. It lets us correct the fast heartbeat using a very risk procedure, one that requires only a 24-hour hospital stay, about two to three days of recovery. These kids can go on to lead normal lives, which has a tremendous psychological benefit as well.



HOW DO YOU WORK WITH REFERRING PHYSICIANS SO THAT, WHILE YOU ARE A RESOURCE TO THEM, YOU DON'T COME ACROSS AS TRYING TO DIMINISH THEIR OWN RELATIONSHIP WITH THEIR PATIENTS?

We make sure we stay in touch with the referring physician at all times. For example, we fax them a handwritten report the same day we perform ablation. In addition, since a lot of our patients come from out of town, we travel to other cities to get to know the primary care doctors.

WHAT DO REFERRING PHYSICIANS THINK ARE THE KEYS TO EXCELLENT PEDIATRIC SPECIALTY CARE?

They want a cure, which isn't always possible, but they know we'll do everything in our power. They know we have their patients' best interests at heart.

CAN YOU RELATE AN INTERESTING CASE WHICH EXEMPLIFIES THE TRUST OF REFERRING PHYSICIANS IN YOUR SPECIALTY CARE HERE AT COOK CHILDREN'S?

Well, there have been quite a few interesting and rewarding cases. Children who suffer from cardiac arrhythmia come to us from all over the globe, and the radio frequency ablation procedure lets us correct about 90% of the problems we see. We get to send a lot of kids back home very healthy, very happy.

Cook Children's Medical Center is located in Fort Worth, Texas. For more information about Dr. Gillette and our other doctors of Cardiology — J. Hudson Allender, Christopher L. Case, Susan Hess, Stephen Lai, Daniel Miga, Richard Readinger and Matthew M. Weinecke, call 1-800-COOK517.

CookChildren's
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Forum On Ethics

The conspiracy of silence

By Judy C. Googins, MD

The prevalence of psychiatric and substance abuse disorders in physicians is as great as in the general population. Yet, we as physicians often fail to recognize clues that might indicate impairment in our colleagues. Even if we do notice behavioral signs, we often are reluctant to speak to the colleague, address the problem, or report the behavior to the appropriate authority. Instead, we participate in a conspiracy of silence, behaving like the members of a dysfunctional family who ignore the alcoholic in their midst and pretend that life is normal, while enabling the alcoholic to continue in his or her addiction and become progressively more ill.

Consider Dr John Smith (a fictional name to demonstrate a typical case scenario). He is a successful surgeon in his mid-40s with a wife and children and a busy small group practice. He admits numerous patients to the local hospital, generates a great deal of revenue, and often is seen at the hospital well after the dinner hour making his rounds. He is a private person — a driven perfectionist who finished in the top of his class in medical school and is admired by colleagues and respected in the community.

Over the past few months, Dr Smith has seemed more stressed than usual, probably because of a malpractice suit filed against him after a patient died in surgery. Friends observed at a New Year's party that he drank excessively, but they felt he had a right to blow off some steam, considering the pressure he was under. Someone in his office mentioned that he was having marital problems and had been short-tempered toward his office staff as well. The OR nurse complained he was late to surgery and often surly and somnolent. His group members grumbled that Dr Smith was inattentive to their patients when taking call. The clinic received concerned comments from patients regarding Dr Smith's tardiness, prescription errors, and personal appearance. Some noticed that he had lost weight and asked if he was ill.

None of the office staff, patients, or colleagues approached John. The hospital staff thought he would be better when the lawsuit was over. They were dismayed and shocked when the local paper reported his suicide. Everyone wondered, "What could I have done?"

We all can do something to prevent such needless waste of a life and career. We are all guilty if we are informed and then do not act to intervene when we suspect a problem exists. Additionally, we may be legally liable if we know that a physician may be impaired and do nothing about it. But, where do we start? What can the medical community do to address and prevent physician impairment problems?

Recognize the risk

Physicians first must recognize that they are at higher risk of burnout than the general population. This higher risk stems from at least three sources — stressors unique to the medical profession itself, such as long years of preparation, dealing with life and death issues, and maintaining clinical competence; third parties outside medicine (which physicians identify as the most stressful) such as managed care entities, government agencies, insurance companies, and lawyers; and the personalities and backgrounds of physicians themselves. Dr Smith exhibited personality traits common to alcoholics and was under the added stress of a lawsuit and marital problems.

Be aware of vulnerability

Most physicians understand the impact of their profession and of outside influences on their stress levels, but they may not understand how their own personalities cause them problems. At least 25% of physicians come from families where there was addiction or alcoholism, according to Kent E. Neff, MD, director of the Professional Assessment Program at Abbott Northwestern Hospital in Minneapolis. This upbringing predisposes doctors to addictions of their own, to interpersonal problems, and to certain unhealthy behaviors such as perfectionism, workaholism, inability to set limits, and obsessive-compulsive tendencies. Many have difficulty talking about feelings and seldom ask for help, avoiding self-scrutiny. They may have learned maladaptive coping strategies. These behaviors continue as physicians complete their medical training and enter

Dr Googins is a psychiatrist in Midland and a member of the TMA Committee on Physician Health and Rehabilitation.

Texas Medicine **welcomes comments about issues discussed in the Forum on Ethics. If you would like to comment or submit a column for possible publication, please contact Teri Moran, senior editor, at *Texas Medicine*, 401 W 15th St, Austin, TX 78701; phone (800) 880-1300, ext 1371, or (512) 370-1371; fax (512) 370-1632; or e-mail teri_m@texmed.org. Proposed columns must be no longer than 900 words and written in a case study format.**

the community at large. When confronted with stressful events, physicians, being inherently vulnerable, will not automatically choose the healthiest response. They seldom seek the help of mental health professionals or even other physicians and often self-prescribe, making their problems worse.

Dr Smith's unhealthy responses included alcohol abuse and withdrawal from others. However, the response of the community was equally unhealthy. The people who knew him best ignored or failed to recognize signs of depression and substance abuse. Their silence and failure to act may have stemmed from their own unhealthy attitudes and lack of problem-solving skills.

Provide support during critical periods

When confronted with a malpractice suit, at least 40% of physicians experience a clinical depression (1). Approximately one third of residents suffer a major depressive episode during their postgraduate years (2). Substance abuse may be an attempt to self-medicate.

Physicians and the medical community should be aware of the alarmingly high rate of depression during critical periods and make support systems routinely available rather than offering assistance only when the situation requires emergency intervention.

Educate early and continually

Medical students receive very little training about impairment and vulnerability to stress. They enter school with excellent academic records but have little insight into their own personalities or those of physicians in general. Encouraging self-examination at the onset of medical education would both empower students to handle stress and enable them to offer assistance to colleagues when needed. Continuing education about physician stress, burnout, and impairment will make the medical community at large healthier and more supportive.

Intervene when necessary

Even with excellent education and prevention strategies, some physicians will become impaired — those like Dr Smith. We must have the courage to intervene.

TIPS ON HOW TO PUT YOUR PATIENTS FIRST

BEST Practices

Responsibilities in the patient-physician relationship

THE PATIENT	THE PHYSICIAN
Be truthful.	Act with the highest professional competence.
Give the relationship time.	Act without regard to the patient's ethnic group, race, class, or gender.
Take responsibility for learning.	Learn the skills of communication.
Take responsibility for your health history.	Let patients raise topics important to them.
Respect the confidentiality of communication.	Acknowledge the patient's other roles, life situations, and finances in choosing a course of treatment.
Be open to a partnership in decision making.	Work together with other professionals.
Raise issues of concern.	Help patients understand and absorb medical developments.
Respect the physician.	Be responsible.
Do not violate moral boundaries.	Respect confidentiality.
Involve your family in your care.	Respect the patient and respect the role of the spouse and other family members.

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The goals of intervention with a colleague are different than those with patients. It is not our responsibility to diagnose or recommend treatment, but rather to acknowledge a problem exists and arrange for an objective evaluation. If treatment is then recommended, we must provide the opportunity for our colleague to receive it and then support him or her in the recovery process. If treatment is refused, we must be willing to go beyond intervention and report the problem.

Dr Smith may have been suffering from alcoholism, depression, or something else; it is difficult to know. It is not difficult, however, to recognize that he needed help. We neglect our ethical responsibility if we continue to participate in a conspiracy of silence. ★

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1. Charles SC, Wilbert JR, Kennedy EC. Physicians' self-reports of reactions to malpractice litigation. *Am J Psychiatry*. 1984;141:563–565.
2. Valko RJ, Clayton PJ. Depression in the internship. *Dis Nerv Syst*. 1975;36:26–29.

Americans unaware of painkiller risks

Results of a survey commissioned by the Johnson & Johnson unit of McNeil Consumer Products have prompted McNeil to team up with the American Pharmaceutical Association on an educational campaign about the risks of aspirin and other nonsteroidal anti-inflammatory drugs (NSAIDs).

A Reuters report published the results of the survey, which said 85% of the 1,000 people polled had taken a pain reliever such as aspirin or ibuprofen at some point, but 47% said they did not always read the labels and a third were not aware of the risks associated with the drugs. The survey also found that nearly 75% of Americans do not know that aspirin and other NSAIDs can cause potentially fatal stomach bleeding with normal use, and nearly 45% did not know the danger of mixing painkillers with some prescription medications.

Pharmaceutical companies are developing new painkillers, known as COX-2 inhibitors, that lack these side effects. ★

Stampede to Super Saturday

Lasso tough issues at TexMed '99 symposia
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Cancer: What Primary Care Physicians Need to Know

9 am - 5 pm

- Cancer Screenings, Tamoxifen, and PSA tests
- Genetic Evaluation
- Quality of Life

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Presented by TMA's Physician Oncology Education Program and Committee on Cancer

Symposium on Pediatrics

9 am - Noon

- At-Risk Behaviors in Adolescents
- Lumps and Bumps
- Childhood Obesity

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It just makes sense

TECAP gets everyone reading off the same page for office reviews

Regan Dunnick

You know the drill. You're a primary care physician, obstetrician-gynecologist, or a specialist who sees large numbers of managed care patients. You've had plan after plan after plan knock, knock, knocking on your door. They're conducting site surveys and medical record reviews, each with a slightly different twist but all looking essentially for the same thing — evidence that you are giving your patients high-quality health services in a safe environment. ➤➤

By Laurie Stoneham

These office reviews are part of the process managed care organizations voluntarily go through every other year to receive accreditation from the National Committee for Quality Assurance (NCQA) and to meet the regulatory requirements of the Texas Department of Health (TDH) and the Texas Department of Insurance (TDI).

But because each plan is measured against the same standards, many physicians feel the process of all the plans visiting all the offices is unnecessarily intrusive and disruptive.

Administrative absurdity

Bohn Allen, MD, a general surgeon in Arlington, is on the panels of 26 different managed care plans. During 1997, his office was reviewed 14 times. Because he's a solo practitioner and what's known as a "high-volume specialist," the process was fairly easy. "We've gotten so good at this that we tell the reviewers what they should be looking for," he said.

But consider what it would mean for large primary care groups, where the files of each physician have to be pulled, examined, and evaluated. What took a little more than an hour for Dr Allen could turn into a couple of days for these large groups. Then multiply that by numerous plans.

While there is little argument about the importance of reviewing quality-of-care practices, the time devoted to these largely redundant exercises verges on the absurd. Virginia Moore, MD, medical director of Prudential HealthCare-North Texas, points out, "Doctors don't keep different medical records for Prudential than they keep for CIGNA or for Aetna or for Harris." Requirements for the site surveys of parking lots, office layouts, and practice procedures don't change either.

reviewers; transportation costs; nonproductive travel time; survey design; report writing; and elaborate database systems for inputting, storing, managing, and retrieving the data collected.

Many organizations employ registered nurses for the medical record reviews, while provider relations representatives complete the site surveys (sometimes in separate visits). These costs add up to the tune of $50 to $300 per physician, according to plan estimates.

> "We tried to put together an instrument that reflected both what the plans and our members thought would be a good standard and then outline a process that would be fair, effective, and comprehensive in applying the instrument."

The expense

Along with the hassles for physicians, meeting credentialing and regulatory requirements results in a substantial administrative burden and cost for managed care organizations. It requires salary, benefits, and overhead for the

A better way

Recognizing the dilemma, Texas Medical Association's Medical Directors' Forum established a workgroup to see if the process could be simplified to offer plans and physicians an easier, more consistent, and efficient way to meet regulatory requirements.

"Medical directors agreed that there's pretty high variability in how all of them actually conduct these reviews," said Rich Johnson, director of TMA's Division of Medical Economics. "They thought there should be some generally accepted standard about the elements that you look at and the way that you proceed with the review. So, on both counts, we tried to put together an instrument that reflected both what the plans and our members thought would be a good standard and then outline a process that would be fair, effective, and comprehensive in applying the instrument."

The result of that effort is the Texas Environment of Care Assessment Program (TECAP). After working with representatives of health plans and regulatory agencies, the workgroup developed a single instrument that satisfies all the NCQA, TDH, and TDI office site and medical record review requirements. It offers consistency and uniformity throughout

TMA Advantage: A capsule view of TECAP

The Texas Environment of Care Assessment Program:

- **Provides comprehensive site surveys and medical record reviews that fulfill all applicable regulatory requirements of the National Committee for Quality Assurance (NCQA), Texas Department of Health (TDH), and Texas Department of Insurance.**
- **Is approved by NCQA to meet CR 6, CR 10, and MR 2.1 accreditation standards.**
- **Is approved by TDH to satisfy Medicaid managed care credentialing requirements.**
- **Is a living document that will change as regulatory requirements change.**
- **Has a trained staff of registered nurses who conduct surveys.**
- **Is governed by a user's board consisting of plan and agency representatives who will provide policy oversight.**

For more information about TECAP, contact Lisa Harmon in TMA's Division of Public Health and Quality at (800) 880-1300, ext 1400, or (512) 370-1400; e-mail tecap@texmed.org; or visit TMA's TECAP Web site at tecap.texmed.org.

the review process. Two years in the making, it's modeled after a program that's been implemented successfully by the Oregon Medical Association.

Reducing the hassle

The strategy is simple. TMA uses the instrument to perform reviews of physician practices. Specifically trained registered nurses will conduct both the medical record reviews and site surveys. Participating managed care organizations can then purchase the data from TMA as needed.

"It's an effort to reduce the number of interventions that have to occur now at the office level," said Rufus Stanley, MD, managed care medical director for Blue Cross Blue Shield of Texas and chair of the TECAP workgroup. "We're really trying to meet the needs of practicing physicians by attempting to reduce the number of knocks on their doors."

TECAP represents potential cost efficiencies for the plans, as well. Stan Pomarantz, MD, is vice president of medical affairs for System Health Providers, the management company for the 1,200-member Genesis Physicians Practice Association in North Texas. "In my way of thinking, if the health plans already are doing these surveys and are required to do them, then why have that cost and why have to manage the function? Why not gain some economy of scale by doing them collectively with other health plans statewide? It just makes more sense."

The review process

So what are the reviews about? The mission of NCQA (see "Everything You Ever Wanted to Know About NCQA" on this page) is to offer insurance purchasers a way to judge managed care plans on the basis of objective quality standards. While not all health plans participate in the voluntary accreditation program, the major insurers do. "It's sort of seen as the *Good Housekeeping* Seal of Approval," Dr Moore said. An increasing number of employers are demanding that plans have this approval, so it's a market-driven phenomenon. NCQA says the TECAP instrument complies with its standards for office site visits and reviews of medical records.

Everything you ever wanted to know about NCQA

NCQA stands for National Committee for Quality Assurance.

What: **NCQA is a private, nonprofit accrediting organization with a mission to assess and report on the quality of managed care plans.**

When: **NCQA has been accrediting managed care organizations since 1991.**

Why: **NCQA helps employers and consumers make better-informed purchasing decisions, based on objective, standardized information about the quality of health plans.**

Accreditation process

NCQA accreditation is voluntary but rigorous. More than half of the plans in the country undergo the process, involving measurement against some 60 standards that fall into six categories:

- **Quality management and improvement — quality of care delivered, delivery system, access to care, and demonstrated improvements in quality and service.**
- **Credentialing — physician training, experience, and performance.**
- **Members' rights and responsibilities — communicating with and responsiveness toward plan members.**
- **Preventive health services — support, provision, and monitoring of preventive services.**
- **Utilization management — system for managing health services used.**
- **Medical records — review of medical records against NCQA standards.**

TECAP meets all applicable standards in the quality management and improvement and medical record categories.

Accreditation levels

Full: meets all NCQA standards and is accredited for 3 years
One-year: meets most standards
Provisional: will involve reaccreditation, 1-year status
Denial: has a major deficiency and low score

Other activities

NCQA also manages performance measurement tools for managed care, the Health Plan Employer Data and Information Set (HEDIS). Starting in July 1999, HEDIS results will be incorporated into the accreditation process.

To learn more about NCQA and the accreditation status of health plans, contact NCQA at (888) 275-7585 or access its Web site at www.ncqa.org.

TDH mandates that health maintenance organizations (HMOs) demonstrate evidence of ongoing quality of care. These regulations state, "The quality improvement program shall be continuous and comprehensive, including both the quality of clinical care and the quality of service requiring updates as needed." Beverly Koops, MD, medical director of health care financing at TDH, has approved TECAP as meeting its requirements for office visits and medical record reviews for "credentialing physicians as acceptable providers in the Medicaid managed care provider networks."

TDI also requires licensed HMOs to perform site reviews to ensure that physicians are meeting an acceptable quality-of-care standard. Many of the requirements of NCQA and the state agencies overlap, and the TECAP instrument provides consistent and comprehensive compliance.

What's being evaluated

The site survey evaluates areas such as office accessibility, cleanliness, and safety; office procedures for scheduling, tracking medical records, and handling patient emergencies; provisions for patient convenience and confidentiality; and display of licenses.

The medical record review involves looking at six randomly pulled charts to ensure that patient demographics are noted properly. The charts must be well organized, and provide complete and thorough documentation of history, diagnosis, outside referrals, test results, and treatment plans, and evidence of preventive services.

"The whole point is to improve quality and outcomes of care," Dr Moore notes. She says the surveys have never been designed to be punitive, but rather to be a vehicle for working with physicians and offering them "positive feedback."

However, Joe Cunningham, MD, sees it somewhat differently. "There's a level of fear and tension when some surveyors come in to evaluate the office, rather than a cooperative spirit about what could be done to make the practice run more smoothly." Dr Cunningham, executive director of Providence Health Alliance in Waco, believes TECAP offers a less adversarial method.

If a physician needs assistance in a particular area, TMA can offer help without pointing fingers. "We'll be able to identify what the pattern issues are and provide the services the physician needs to comply with the audits," said Lisa Harmon, director of the TMA Science and Quality Department, who currently oversees the TECAP program.

Dr Cunningham thinks TECAP will be a valuable resource for TDH as it enters the Medicaid managed care market because it provides "a standardized office assessment that doesn't drive practitioners away from this underserved population."

"TECAP is physician driven and physician monitored, and it's in the best interest of physicians."

High-level oversight

NCQA requires oversight of delegated duties. The TECAP User's Board will consist of representatives from each participating managed care organization. Each plan will have a vote.

"They will be high-level managers of the program," said Karen Batory, director of TMA's Division of Public Health and Quality. "We have the ability to bring regulators to the table, and there's a lot of value in that. We'll know firsthand what TDI wants, for example, and work with the plans to help them meet that need."

Dr Allen, chair of the TMA Council on Socioeconomics, agrees that the physician leadership component offers the ideal mix of expertise. "TECAP is physician driven and physician monitored, and it's in the best interest of physicians. TECAP makes the process fair and easy and gives it credibility."

Major move toward collaboration

TECAP makes for some strange bedfellows between TMA and the health insurance plans it sometimes takes to task over policy issues. "Obviously, we all agree to disagree on some things," Mr Johnson said. "But this is something that we can all do together, something that benefits both the plans (from the standpoint of being an efficient and cost-reducing tool for them) and the practicing physicians (in terms of being good for their business and operational and practice interests)."

Dr Pomarantz added, "We need to be looking toward rationalizing the administrative system of health care delivery and not making it more difficult, which seems to be the pattern that's occurred in the past number of years. I think it's incumbent upon the health plans to work collaboratively with TMA and providers around the state to make this work."

"This does seem to be a white-hat issue," Dr Cunningham noted. "It's a chance for the managed care industry to put its money where its mouth is when saying that its interest is in improving quality of care and that managed care organizations do not intend to increase the hassle factor on practicing physicians to the detriment of patient care."

Dr Stanley sees TECAP as a "watershed effort" for Texas. "This is a collaborative effort between the managed care industry and the practicing community to begin to streamline some of these activities and make it easier to make managed care doable."

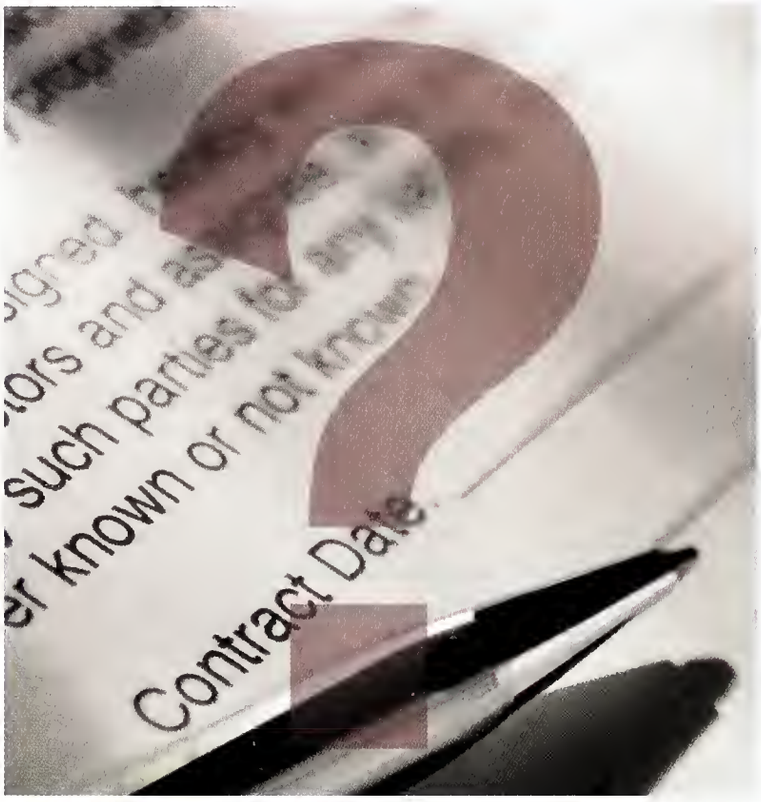
He continued, "It will convey a message from the managed care industry of Texas to the practicing community that we're listening to its concerns and that we must work together on behalf of the patient in this environment in which we find ourselves."

Dr Cunningham also suggests, as others have, that which health plans step up to the plate to make TECAP a viable program will be very telling. "This is going to line up plans that are willing to work with physicians versus those that have a more arrogant and condescending attitude." ★

Laurie Stoneham is a freelance writer in Austin.

See you in court?

New attorney general noncommittal on future of HMO lawsuits



The hard-won managed care reforms that the Texas Medical Association pushed through the 1997 session of the Texas Legislature gained currency in December when outgoing Texas Atty Gen Dan Morales filed three lawsuits against six health maintenance organizations (HMOs). Mr Morales sued the HMOs, alleging several violations of state laws, just weeks before turning over his office to new Atty Gen John Cornyn.

At press time, Mr Cornyn hadn't said how he would pursue the lawsuits, saying only that he plans to review them. ➤➤

By Teri Moran, Senior editor

The lawsuits charge all six HMOs with having contracts with physicians that induce them to limit medically necessary care by penalizing them for exceeding patient-care financial targets. Other allegations against some of the plans include misleading members about emergency care coverage, availability of specialist physicians, and how referrals to specialists are handled. Several plans routinely refused to pay for emergency visits when members did not get prior authorization or when emergency physicians later did not code the visits as emergencies, the lawsuit states.

In state district court in Travis County, Mr Morales filed one lawsuit against Humana Health Plan of Texas, Inc, and another against PacifiCare of Texas, Inc. The third lawsuit names Aetna US Healthcare, Inc; Aetna Health Plans of North Texas, Inc; NYLCare Health Plans of the Southwest, Inc; and NYLCare Health Plans of the Gulf Coast, Inc. Aetna bought NYLCare in July 1998 but has not integrated it fully into its operations.

Medical decisions are "reserved for patients' doctors, and those doctors should not be manipulated by the HMOs," Mr Morales said in a December statement announcing the lawsuit. Mr Morales asked the court to prohibit the HMOs from continuing these activities and to order them to pay civil penalties, attorney's fees, and court costs.

TMA member surveys consistently have shown that many HMOs have been ignoring the new laws. Bringing their noncompliance to the attention of state authorities has been a high TMA priority.

"Over the past several years, our physicians and their patients have frequently expressed concerns about managed care contract provisions that raised the possibility of financial conflict," said TMA President John P. Howe III, MD. "Physicians have been knocking on the health plans' doors for years, offering to review contracts that contain financial incentives and to help develop payment systems that allow doctors to advocate for their patients' medical care. If the HMOs had answered the door, these lawsuits might have been avoided."

Although Mr Morales' staff had been in negotiations with the defendant plans for months, the lawsuits took many observers by surprise, coming as they did just weeks before Mr Morales left office. And while the future of the cases remains unknown — they could be settled or litigated — the very fact that the attorney general's office filed them brings hope that alleged managed care abuses may not continue unabated.

When profits are the bottom line

Medicine has long asserted that many HMOs have an unseemly bent toward putting profits before patients. Texas was the first state to outlaw the industry's practice of penalizing physicians for spending too much money on their patients.

In the attorney general's cases, all six HMOs have been charged with violating the 1997 law by using various illegal financial arrangements in their contracts with physicians. In all three lawsuits, this exact wording is found: "Through these arrangements, [Aetna, Humana, PacifiCare, NYLCare] attempts to induce its contracting physicians to limit treatment to members in order to maximize their profits. These incentive arrangements act as an inducement to limit medically necessary services. . . ."

Texas Medicine spoke with Aetna, Humana, and PacifiCare officials, who dispute the allegations. "We categorically deny that we are doing anything wrong," said Tony Salters, spokesperson for PacifiCare of Texas, Inc. "The way we do business with our physicians and draw up our contracts, we believe, is in compliance with what the federal and regulatory agencies say we can do."

Humana Health Plan of Texas, Inc, spokesperson Ross McLerran said that all of Humana's physician contracts have been reviewed and approved by the Texas Department of Insurance (TDI) and the Health Care Financing Administration. "We believe those contracts provide incentives for appropriate care and service."

The HMOs say the lawsuits were unexpected. Former Insurance Commissioner Elton Bomer, in addition to monitoring HMO contracts, created a task force last summer to develop policies and guidelines for HMO compliance. Mr Salters said no resolution had come out of the meetings before Mr Bomer left office and that they have been left hanging. About the same time, the attorney general filed suit. "That's what caught everyone off guard, because we were looking for some type of response back from what had been going on in the [TDI] roundtable discussions," Mr Salters said.

Aetna spokesperson Jill Griffiths says Mr Morales' lawsuit came as a complete surprise, especially because Aetna had been working closely with his office since last April and had opened its operations for inspection. "We believe that we complied with the vast majority of issues raised by the attorney general," she said, including, for example, Aetna's across-the-board acceptance of the "prudent layperson" definition of emergency care. Ms Griffiths takes special exception to the lawsuit's accusation that some of Aetna's physician contracts include gag clauses, which she says do not exist.

A former official in Mr Morales' ad-

"Physicians have been knocking on the health plans' doors for years, offering to review contracts that contain financial incentives and to help develop payment systems that allow doctors to advocate for their patients' medical care."

Legal articles in *Texas Medicine* are intended to help physicians understand the law by providing legal information on selected topics. These articles are published with the understanding that TMA is not engaged in providing legal advice. When dealing with specific legal matters, readers should seek assistance from their attorneys.

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ministration who did not wish to be identified told *Texas Medicine* that negotiations between the attorney general's office and the HMOs had been ongoing for months before the suits were filed. The HMOs were given the opportunity to "clean up their acts," the source said, but kept lagging. They then were given a deadline, then an extension of the deadline, but when they missed it, the source says, Mr Morales filed suit.

False claims

All six HMOs also have been charged with deceptive trade practices for telling their members one thing and doing another. None of them allegedly disclose to their members the nature of their financial incentive arrangements with physicians, for instance.

All six have been charged with giving their members false, misleading, or deceptive information about emergency care services. Humana is charged with telling members that medical necessity decisions will be made by the member's primary care physician or, in emergency situations, by the attending physician, when Humana allegedly bases coverage decisions on its own determinations of medical necessity.

The suit says PacifiCare tells members that emergency services are covered, but it allegedly fails to disclose that PacifiCare will determine after the fact whether a member really had an emergency. PacifiCare also allegedly repeatedly denies emergency care claims based on a member's failure to get prior authorization, even though it tells members no prior authorizations are required.

Aetna's and NYLCare's member materials also say that no prior authorization for emergency care is required and that emergency care outside the covered area will be paid for, the lawsuit says. But the materials allegedly fail to add that emergency care claims will be denied without prior authorization and when the care is rendered outside the service area.

All the rest

Although each HMO is charged with doing it somewhat differently, all are accused of misleading members about who actually makes medical necessity

decisions about their care. The six HMOs allegedly tell patients that their physicians have that authority when, in fact, the HMOs do not bind themselves to the physicians' decisions.

Additionally, Humana, Aetna, and NYLCare are accused of misrepresenting the availability of specialist physicians. Humana also allegedly misrepresents the manner in which referrals are made. And the lawsuit says Aetna, NYLCare, and PacifiCare do not appropriately handle medical claims.

Not the first time

The lawsuits are high-profile cases against some of the largest players in the Texas HMO industry, but they are not the first filed under the law forbidding illegal physician contracts. Last June, a state judge ordered Harris Methodist Health Plan, a dominant health care provider in North Texas, to end its contracts with physicians that penalized them for providing medically necessary care. Harris had been on the receiving end of three such lawsuits, and it was the third one, a class action suit filed by hundreds of physicians, in which the judge ordered Harris to rewrite its contracts with all of its physicians. TMA's Office of the General Counsel filed four "friend of the court" briefs supporting the physicians in that case. Mr Bomer also fined Harris $100,000 and ordered it to repay $3.4 million to physicians in penalties and lost bonuses.

Many Texas physicians view these lawsuits as a victory in medicine's struggles to hold managed care accountable for its practices, and hope that Mr Cornyn continues to enforce vigorously the 1997 managed care reforms. "We support the medical code of ethics that requires physicians to be free of financial conflicts that may affect their clinical objectivity," Dr Howe said. "And while there are health plans in Texas that adhere fully to the letter and spirit of those 1997 reforms, Texas physicians are opposed inalterably to any financial scheme that interferes with our ability to provide proper medical care to our patients." ★

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STRESS, BURNOUT, AND ADDICTION

Physicians share their stories of recovery and prevention. By Johanna Franke, Associate editor. In today's world of stress sufferers, not everyone is equal. Just by entering the medical profession, physicians throw themselves into a higher stress bracket, and this bracket comes complete with greater consequences. Addiction and burnout are two of these consequences, but they don't have to be.

BACK FROM THE BRINK

PHR program helps physicians save their lives and careers. They were trained to help and heal people, but instead they found themselves in desperate need of help to escape the grip of drugs and alcohol. Now, thanks to assistance from a special Texas Medical Association program that has helped many others like them, two Texas physician addicts have completed drug programs successfully and still are practicing medicine.

In the end, they were the lucky ones. For too many physicians, addiction to drugs or alcohol — often caused by the stress of modern medicine — leads to suicide.

"Every year it takes about two complete classes of medical students to replace the number of physicians who commit suicide," said Abraham Verghese, MD, a professor of medicine and chief of infectious diseases at Texas Tech University Health Sciences Center in El Paso. "It's almost 200 students. The most common cause of premature death among physicians is suicide, and half of those suicides are related in some way to drug abuse or addiction," he said.

Dr Verghese has seen firsthand the desperation of a drug-addicted physician and what it can lead to. He has written a book about the experience, *The Tennis Partner: A Doctor's Story of Friendship and Loss,* and will discuss it during the May 6 general session at TexMed '99 (see "TexMed '99 Offers Education, Recreation," pp 20-23).

David Smith, MD, was a recovering intravenous cocaine addict when he met Dr Verghese at Texas Tech in El Paso. They became fast friends because of their common passions for medicine and tennis. But Dr Smith soon succumbed to his addiction, or his "disease of secrecy and aloneness," as Dr Verghese described it. When Dr Smith committed suicide, Dr Verghese says, he made a final statement that is at the core of addiction: "I walk alone. I take my secrets with me."

But physician recovery rates are higher than in any other profession because once they're caught, doctors lose their licenses, Dr Verghese said. "For so many physicians, it is not just their livelihood, it is who they are. Their whole identity is wrapped up in this profession, so there's a tremendous incentive to get sober, to get straight, and to rehabilitate."

Ruin and redemption

The stories told by two Texas physicians are examples of how TMA's Committee on Physician Health and Rehabilitation (PHR) can help doctors (see "TMA Advantage," p 47).

(Continued on p 46)

I JUST HAD TO LET IT GO

By George Bohmfalk, MD. After practicing neurosurgery for 18 years in Texarkana, I quit about a year and a half ago. I reckon there may be a half-dozen reasons that physicians keep practicing beyond 15 or so years, and a million reasons to quit. The first, and perhaps the only good one to continue, is the love for it. A second could be a sense of moral obligation or duty to society, a payback for all that training we received. A less magnanimous reason may be the material trappings, a reluctance to surrender the lifestyle that generally accompanies this line of work. Another could be the prestige and esteem that most of us enjoy. There may be pressures, subtle or not so subtle, from spouses and other family members who enjoy and don't want to give up the last two. Finally, some friends tell me they'd quit but they don't know what else they'd do.

Of the myriad reasons to quit, one mainly hears about lawsuits, suffocating paperwork, the perverseness of managed care, threatened incomes, and loss of autonomy. I did not really have major problems with those.

I really loved practicing for the first 10 or 12 years. By the time I realized that, in the aggregate, I didn't love it anymore, the only reason to continue was this sense of obligation, like practicing was what I was supposed to do. The other considerations fortunately weren't really factors for me or my family.

In the process of examining whether I was burned out, crazy to give up such a successful, honorable, and lucrative practice, or whether Reason No. 2, "the moral obligation issue," was compelling enough to keep me going, I spoke with a friendly psychiatrist. In his opinion, burnout involves some amount of depression, such that one may treat the depression and get docs back in the saddle, if in some different practice arrangement than before. He differentiated my non-depressed situation, which for lack of a better term may be called "tired of," from burnout. As for Reason No. 2, we agreed that martyrs probably don't make the best physicians.

One unresolved issue is whether I would have been so eager to quit had I not had another career interest. I wonder whether that interest has been artificially magnified by my desire to leave medicine or whether that genuine interest magnified my dissatisfaction with medicine. I thought for a long while that, if I could limit my practice to only the "good stuff" that I still enjoyed

(Continued on p 48)

(Continued from p 44)

The first physician, who wishes to remain anonymous, turned to drugs and alcohol for relief from stress caused by a divorce, a new marriage, a new baby, and the construction of a new house. "It was certainly a bad decision, but one of the subtleties about drugs and alcohol is that we convince ourselves that it was a good decision, and we continue to use drugs in the face of ever-increasing problems. It's a process called denial."

As an anesthesiologist, this physician had easy access to narcotics and hallucinogens. As a doctor, he believed he had all the answers. "Society pumps us up and puts us on a pedestal," the physician said. "We don't like to ask for help. I felt like I was totally self-sufficient."

Though his addiction lasted only 8 months, it was fast-paced. Soon the physician's colleagues had consulted TMA PHR committee members, who broke through the physician's denial and made him really look at his disease. He was taken immediately to a treatment center, from which he called his parents.

"You can't imagine what it feels like to be your mom and dad's hero because you got into medical school and you made it all the way," the physician said. "I'm almost in tears now thinking about the fact that I had to call them on the phone and say, 'I'm in a drug treatment facility because I'm a drug addict.'"

After a relapse, another divorce, the loss of his house, and 2½ months of treatment, the physician was clean and sober and still had his medical license.

"The PHR committee acted as a buffer between me and the Texas State Board of Medical Examiners (TSBME)," he said. "The committee took the problem over at the local level, monitored me, and made assessments that the board wouldn't have been able to do from Austin."

Today, the physician deals with stress by using what he's learned in 12-step meetings, which require him to accept that there's some mystery in life that he will never understand. "I had to give up on understanding, which is really tough for many physicians because we were trained for 4 years in medical school to understand everything."

The physician also reminds himself of a quote in the book *Alcoholics Anonymous,* "There is a principle which is a bar against all information, which is proof against all argument and which cannot fail to keep a man in everlasting ignorance — that principle is contempt prior to investigation."

To other doctors struggling with addiction, the physician said, "You need to be willing to reach for help because help is there. People do care and people want to help, but you have to get past the pride, the fear, and the ego."

Though the PHR committee members were initially "the enemy," the physician says he appreciates the assistance they provided him. "I'm extremely thankful that these people cared enough to be in that position because, if you look at it, it's a tough-love place. These guys aren't on any kind of power trip."

In fact, Herbert C. Munden, Jr, MD, a former TMA PHR committee member who continues to do interventions with his local PHR committee members, was once in that physician's place.

Despite acquiring an addiction to alcohol and drugs before he graduated from high school, Dr Munden was able to maintain high marks through college and medical school and do well in a family practice residency. By then, he was abusing amphetamines, narcotics, marijuana, and alcohol.

"You need to be willing to reach for help because help is there. People do care and people want to help, but you have to get past the pride, the fear, and the ego."

"I decided to quit my residency and the stress of it," Dr Munden said. "By then, I knew there was a problem, but I called it residency, and I called it my family, which was riddled with alcoholism and drug addiction."

In 1978, Dr Munden took over a family practice in Elgin and promised himself he'd quit abusing drugs, as he was about to get married and start a family. But the first day on the job, he received the key to the narcotics box and started using again. "I had a briefcase that I took to work and I never had anything in it," Dr Munden said. "But I always cleaned out every controlled substance that I could get my hands on — it was my controlled substance briefcase. And if I worked a minor emergency center, I'd steal everything there. I'm not proud of it today. It's really sick."

Two children and 4 years later, Dr Munden's life was completely out of control. He finally learned the true definition of a drug addict when he tried to help a relative get sober by participating in the family member's drug addiction program. One of the program's counselors, he says, "summed up addiction in a sentence: It's where people continue to use drugs despite adverse consequences," he said. "Society had taught me that a drug addict was a homeless person behind a dumpster shooting up heroine." Dr Munden learned that he, too, could be a drug addict.

For the first time in his life, Dr Munden, star student and star athlete, faced something he couldn't handle. He eventually hit bottom when he skipped his child's birthday party to hunt down some cocaine. Two days later on his own birthday, Dr Munden decided to ask his wife for help after taking some Ecstasy that was given to him as a present. His wife did help by standing by him during his 4-month stay at a drug treatment center.

Even though Dr Munden was a "bad patient" at first, he soon realized that "this was serious business." He learned he had a disease. "If there was anything that I got out of that experience, it was to understand that I was sick," he said. "I was not a bad person. I didn't have a lack of will power."

While in treatment, Dr Munden was confronted with the damage his addiction had done. A social worker pelted him with

questions until he cut her off with, "You need to go talk to my roommate. This guy is violent and beat the hell out of his wife. You're asking me all of this garbage and I'm real tired of it."

The social worker responded with, "Then I want you to tell me where you were for your children. Tell me where you were for your wife. Where were you for your patients?" Dr Munden couldn't answer those questions.

Once he returned home clean and sober, Dr Munden was rejected by a multitude of managed care plans because of his drug history. When he called a former therapist to talk about his travails, he was told he could be either part of the problem or part of the solution. Dr Munden chose to be part of the solution and joined his local PHR committee, for which he's participated in nearly 50 interventions.

"Being on the committee is incredibly important to me today," he said. "I've watched these guys go from strung-out addicts to clean and sober physicians. We're the people who can help you before word gets out."

Under state law and TSBME guidelines, physicians are disciplined for intemperate use of alcohol or other drugs when the board believes such use could endanger the lives of patients.

"This does not mean that the board is not supportive of physicians receiving proper treatment," said San Antonio ophthalmologist Robert N. Jones, MD, chair of TMA's Committee on Physician Health and Rehabilitation. "In fact, quite the opposite is true. A physician who voluntarily comes forward and self-reports intemperate use of alcohol or other drugs may be eligible for a confidential rehabilitation order."

Under this law, physicians who are issued confidential rehabilitation orders and continue to be in recovery may not have the fact of their rehabilitation become part of professional liability lawsuits. "Even physicians who are disciplined are given the opportunity to receive treatment and regain their medical licenses," Dr Jones said.

PHR committees act autonomously of the board; however, physicians are provided information so that an informed decision can be made as to whether to self-report to the board. Physicians referred to PHR committees who do not comply

> "I had a briefcase that I took to work and I never had anything in it. But I always cleaned out every controlled substance that I could get my hands on — it was my controlled substance briefcase."

TMA Advantage:
Committee on Physician Health and Rehabilitation resources

HOTLINE

Texas Medical Association's Committee on Physician Health and Rehabilitation (PHR) offers physicians the assistance they need to battle drug or alcohol addiction, depression, senility, or other problems that may disrupt their professional and personal lives. The PHR committee is an advocate for these physicians, and all referrals are confidential. For help, call the PHR committee hotline at (800) 880-1640 or (512) 370-1640.

COURSES

Physicians needing 1 hour of ethics continuing medical education (CME) Category 1 credit toward the American Medical Association Physician's Recognition Award can participate in one of five PHR committee courses offered through meetings, home studies, and the TMA Web site. The ongoing courses, which include "Physician Stress/Burnout," "Alcohol & Other Drug Use Among Physicians," "Intervention for Physicians Who May Be Impaired," "How to Establish a Peer Assistance Committee," and "Care for the Caregiver (Behavioral & Emotional Problems)," can be found on the TMA Web site at www.texmed.org under the "Continuing Medical Education" area of the "Education/CME" section. The courses also are offered in a home study format as well as through meetings with programs presented by PHR committee regional educational team members free of charge to county medical societies, alliances, hospital staffs, and other groups. To obtain a home study course or schedule a speaker, call Linda Kuhn, PHR committee coordinator, at (800) 880-1300, ext 1342, or (512) 370-1342; or e-mail linda_k@texmed.org. Internet and home study participants will be charged a $10 administrative fee.

ASSISTANCE FUND

The PHR committee's Physician Health and Rehabilitation Fund provides financial assistance to physicians who cannot afford treatment for depression, chemical dependency, or other problems. The fund also provides monetary aid to physicians' families who need help with short-term living expenses while physicians receive treatment.

For more information or to make a donation, call Linda Kuhn, PHR committee coordinator, at (800) 880-1300, ext 1342, or (512) 370-1342; or e-mail linda_k@texmed.org.

Cover Story Part One

with recommendations may be reported to the board. If the committee believes the physician is posing a continuing threat to the public welfare through the practice of medicine, and the physician refuses to seek help, a mandatory report is made to the board.

Though his local PHR committee interventions don't always run smoothly, Dr Munden continues to do them because of the Alcoholics Anonymous saying, "You can't keep it unless you share it." Plus, the addicts he confronts are a constant reminder of what could happen to him if he uses drugs again.

"And I'm thankful that God put me in a position of being a physician so that I can share," he said. "There aren't a whole lot of people who can help physicians unless they're police officers or the state board of medical examiners, and by then, it's too late."

During his treatment, Dr Munden also learned what stress is. "It's fear," he said. "It's tomorrow, the next day, the next year — it's something you may or may not get. It's yesterday. It's not now. The way to begin to deal with this word that society gave you is to learn to live in the now.

"I get caught up in stress, too. Through that, I've learned that in the middle of my day, I can change my day if I want to," Dr Munden said. "I just have to change my attitude. And if I place importance on how much money I make or what recommendations I get or what kind of car I drive, I'll be unhappy. If I base my happiness on material things, I will lose every time."

Dr Munden believes stress and burnout are the major sicknesses of society, but everybody's in denial. He wishes physicians had a "Workaholics Anonymous" to help them cut back hours at the office and bring them closer to their families. "So much of it is about recognizing the problem, seeing the toll it's taking, and being willing to make some changes," Dr Munden said. "Being an alcoholic and drug addict is the best thing that's ever happened to me because I've got my life now."

Physicians need to remember that they're human, and as humans, they are mental, physical, and spiritual, Dr Munden says. "You need to take care of all three. Learn how to have fun. Play again. Put medicine third or fourth on the list. Be with your family. Watch your kids grow up."

Most of all, physicians need to know they have help, Dr Munden says. "I think there are thousands and thousands of doctors out there who just don't give a rat's ass whether they live or die because they're so unhappy," he said. "And they don't have to be." ★

TexMed '99 general session presentations

Abraham Verghese, MD
4-5 pm, May 6, Stemmons Auditorium

Mary and Wayne Sotile
8-9 am, May 8, Stemmons Auditorium

Cover Story Part Two

(Continued from p 45)

(like meningiomas, trigeminal neuralgia, carpal tunnels, and other fairly benign, intellectually and technically challenging but comparatively low-stress cases), I might want to keep practicing. That, of course, is impractical with partners who naturally want to do the same thing.

As years passed, I found myself becoming less tolerant of complications and bad outcomes. The better I got, the more perfection I demanded of myself. That seems to be the precise obsessive-compulsive, always striving, never arriving drive that produces and then wears out some surgeons. I wonder if there are only two ways to continue in a stressful practice: miserably, or by developing a distant professional mien, detaching oneself from an emotional investment in the patients and results. I couldn't do the latter, and the former was killing me.

I did feel that the stress was literally going to kill me.

Recipe for burnout

Individual risk factors for burnout

- **Perfectionism**
- **Suppression of feelings**
- **Problems saying no to excessive demands**
- **Feeling both responsible and powerless**
- **Difficulty taking vacations**
- **Social anxiety**
- **Low self-esteem**
- **Obsessive-compulsive personality traits**
- **Unwillingness to talk about problems**

Common personality traits of physicians

- **Perfectionism**
- **Control issues**
- **Doubt**
- **Guilt**
- **Self-sacrifice**
- **Exaggerated sense of responsibility**
- **Difficulty taking vacations and enjoying leisure time**

Expectations of physicians

- **Achieve**
- **Be strong**
- **Know everything**
- **Don't make mistakes**
- **Please everyone**

Source: Texas Medical Association Committee on Physician Health and Rehabilitation. "Physician Stress/Burnout." Home study course. 1997:9.

Many times during particularly difficult or frustrating operations — even ones not threatening to the patient's life, like tough old 4-hour-long arthritic back operations in 80-year-olds — I thought I might drop dead of a heart attack right there at the table. At the tender age of 50, with many more fun things to do in life, that really didn't appeal to me.

Another very powerful emotion was that I would never laugh or feel joy again. This usually accompanied an especially bad result, such as a person dying after surgery, when I, like any conscientious surgeon, would believe that there was something else I could or should have done. Countless times I left the hospital convinced that I had absolutely no right or ability to enjoy any happiness after participating in such an execrable episode. The horrible feeling always passed, usually after no more than 24 to 48 hours, but each episode left a mark. Maybe they finally added up.

At some point a few years ago, I felt that I was being worn out by sickness and injury. I was tired of being faced with pain to relieve and of causing pain in the process. I had enough blood, trauma, crying, and dying. The cured all went away and took the happiness with them. The failed and their misery stayed around forever. I couldn't see that any amount of money, sabbatical, tort reform, or bureaucratic relief could remedy all of that.

A wise medical school professor told my class, "You will each see 20,000 patients during your careers. You can choose to see them in 15 years or 30 years." Maybe I saw my 20,000. Despite predictions from some colleagues who bet that I would eagerly be back within 6 months, I am elated to be free of the stress and burden of practicing. I am fully rested for the first time in too many years; there's a lot to be said for long and uninterrupted sleep. Many people have told me that I look 20 years younger. There's still not enough time to do all the things I want to do, even though it's hard to say exactly what fills my days and weeks. I am for sure smelling the roses, reading some books, making some trips, tinkering with the restaurant business, and staring off into deer-filled woods as I enjoy an afternoon cigar in my hammock. It's not time wasted, but fully savored.

I don't encourage anyone to leave medicine if it's what he or she loves to do, and part of me envies those still bound by passion to it. I just had to let it go. ★

"I was tired of being faced with pain to relieve and of causing pain in the process. I had enough blood, trauma, crying, and dying."

Dr Bohmfalk is a member of the *Texas Medicine* Editorial Committee.

Symptoms of burnout

Behavioral

- Tardiness, absenteeism, medication errors
- Poor record keeping
- Inefficient patient care
- Procrastination, missing of deadlines
- Emotional outbursts, tearfulness
- Avoidance of interaction with people
- Chemical abuse
- Preoccupation with thoughts of relocation

Emotional/psychological

- Apathy, boredom, hopelessness
- Depression, anxiety, poor concentration
- Irritability, critical attitude
- Feeling of alienation and isolation
- Depersonalization of patients
- Sense of low personal accomplishment
- Faulty thinking processes

Physical

- Fatigue, weakness, dizziness
- Rapid pulse, heart palpitations
- Gastrointestinal complaints
- Weight changes
- Sleep difficulties
- Reduced resistance to infection
- Frequent or lingering illnesses
- Hypertension
- Head, back, and muscle aches

Spiritual

- Doubt in beliefs/value system
- Anger/bitterness at your god
- Withdrawal from higher power

Source: Texas Medical Association Committee on Physician Health and Rehabilitation. "Physician Stress & Burnout in an Environment of Change." 1995.

LIVING WITH 'SUCCESS STRESS'

Physicians have help to prevent and bounce back from burnout.

Have you become cynical about the health care system, frequently finding fault with the way things are? Are you dragging at work and dreading the patient encounter? Have you been dwelling on the amount of money you have saved or you are making? Do you drink alcohol, smoke cigarettes, or eat more than is normal for you? Have you strongly considered leaving medicine for another career lately? Do you find yourself taking your frustrations out on your spouse or family members? If you answered most of these questions in the affirmative, you're probably on your way to burnout.

Anatomy of physician stress

Wayne M. Sotile, PhD, a clinical psychologist from Winston-Salem, NC, says we've entered a very interesting time in medicine. "Record numbers of physicians are saying that they would not recommend medicine as a career, and record numbers are claiming they're going to drop out, particularly those over age 55," said Dr Sotile, who, with his wife, Mary, will be speaking in May at TexMed '99, TMA's annual meeting (see "TexMed '99 Offers Education, Recreation," pp 20-23). "But at the same time, record numbers of medical students are entering medical training. I think this is the most stressful time for medical families ever," he said.

Along with regular stressors, physicians suffer from "success stress," said Edgar P. Nace, MD, a Dallas psychiatrist and former chair of TMA's Committee on Physician Health and Rehabilitation (PHR). Physicians with "success stress" have a hard time saying no and take on large and more responsibilities. "All of this is, in some ways, gratifying," Dr Nace said. "But on the other hand, there's stress to it." Dealing with life-and-death situations, time pressures, and chronic fatigue also add to a doctor's stress (see "Additional Stressors Unique to the Medical Profession," opposite page).

"I think every physician experiences stress, and most of the time it's normal stress and is managed effectively," Dr Nace said. "But if stressors increase or if the person's capacity to deal with stress decreases, then that physician is subject to burnout, which is a situation that develops before diagnosable conditions emerge, such as depression, anxiety disorders, or substance abuse."

Recent articles in *The New England Journal of Medicine* and *Hippocrates* say the old problem of physician stress and burnout has been compounded recently by loss of autonomy, payment delays, denial of claims, heavier workloads, and less time for patients. This has led to shorter life spans and elevated rates of substance abuse and alcoholism among physicians compared with comparable socioeconomic groups.

Dr Sotile's formula for physician burnout combines excessive workloads, expanded roles, and lack of support systems.

"Physicians now, as always, work harder than any other profession," he said. Three times more physicians work 60-plus hours a week than workers in other professions do. More than 20% of physicians work more than 80 hours a week, Dr Sotile says.

As far as the most stressed-out specialty, Dr Sotile lists neurosurgeons (see "I Just Had to Let It Go," pp 45-49) and cardiovascular surgeons as the specialists who are required to do more "mass work," with tasks such as 18-hour operations. "But my wife and I have treated just as many dermatologists, who are supposedly on the bottom of the scale in terms of objective measures of stress," he said.

Today, physicians must juggle many roles on top of the many hours they work in a day. During the past 15 years, more women have entered the work force and men have become more involved in their families. More than 40% of medical school students are women, so "'the doctor and his wife' simply does not describe the majority of physician marriages any more," Dr Sotile said. With his wife, Dr Sotile has written two books on medical marriages, *The Medical Marriage: A Couple's Survival Guide* and *Supercouple Syndrome: How Overworked Couples Can Beat Stress Together.*

Women physicians are having an especially difficult time with expanding roles as they try to express their femininity without losing power, prestige, or respect in their profession or their homes, Dr Sotile says. Female physicians need to incorporate femininity into their lives to be whole people, "but that's very difficult when you're working 80 hours a week in a male-dominated arena," he said.

The multiple hours and multiple roles contribute greatly to physician stress, but probably the most heartbreaking ingredient of burnout is the decrease in support and respect for physicians from society. "Physicians, almost universally, are caring people. They're programmed personality-wise to please others and try as hard as they can to be perfect," Dr Sotile said. "I've seen what happens to physicians when they've delivered care out of the goodness of their hearts only to have it turned around in some way and become somebody's lawsuit."

Doctors are lacking professional and community support systems because they don't feel comfortable talking about stress and burnout with colleagues. "It's hard for doctors to acknowledge their vulnerability," Dr Nace said. "They like to take care of everything themselves, and this is not a good strategy for health."

This type of thinking is drilled into future physicians upon entering medical school, says Abraham Verghese, MD, a professor of medicine and chief of infectious diseases at Texas Tech Health Sciences Center in El Paso. Dr Verghese, author of the books *The Tennis Partner: A Doctor's Story of Friendship and Loss* and *My Own Country: A Doctor's Story,* will speak at TexMed '99 in May (see "God Is in the Details," pp 16-17).

"We have the strange paradox of students coming into medicine with a great deal of ability to imagine the suffering of patients and being very capable of expressing emotions," Dr Verghese said. "But there's something about the Citadel-like quality of medical training — only the fittest survive — that creates the situation where they're not really encouraged to talk about their emotions at witnessing the kind of carnage that they witness in the hospital every day. And they just sort of bottle it in."

Stress can cause physicians to become more withdrawn emotionally from colleagues and family, less satisfied with their professional lives, and more irritable and impatient, Dr Nace says (see "Symptoms of Burnout," p 49). "Stressed physicians may have fantasies of changing a practice location, changing practice partners, changing everything with the notion that maybe that would solve what they are going through," he said.

But physicians are an "extraordinarily stress-hearty people" because they deal with stress by developing "high-powered coping strategies," such as going numb, being directive, being quick in decision-making, and ignoring anything other than the task at hand, Dr Sotile says.

"The survival strategies those physicians have to learn to make it in the marketplace end up hurting their relation-

Additional stressors unique to the medical profession

Stressors anticipated when choosing the profession

- **Pressures of time; long years of preparation**
- **Inherent uncertainty involved in patient care**
- **Chronic fatigue**
- **Dealing with life and death or difficult issues**
- **Difficult, demanding, or chronically ill patients**
- **Maintaining clinical competence**

Unanticipated stressors

- **Government regulation**
- **Third-party intrusions**
- **Increase in malpractice litigation**
- **Pressure to practice defensive medicine**
- **Diminished public image of physicians**
- **Breakdown of patient-physician relationship**
- **Inadequate support personnel**
- **Fear of violent patients**
- **Decreased compensation**

Source: Texas Medical Association Committee on Physician Health and Rehabilitation. "Physician Stress/Burnout." Home study course. 1997:5-6.

ships," Dr Sotile said, "and, thereby, pulling the plug on the very things they need to not get burned out, which are caring relationships with other people."

Relationships are the key

After treating 700 physicians during the past 20 years, the Sotiles determined what fuels physician burnout — and it's not what you'd expect.

"None of the research suggests that physician burnout relates to hours worked, practice specialty, managed care, or governmental interference with the practice of medicine," Dr Sotile said. "All those things are aggravations, but they do not differentiate who burns out from who does not."

The research shows physicians burn out when their relationships with the people they work and live with fill with conflict. "My wife and I strongly issue a call to the leaders in medicine to recognize the need for interpersonal skills training for physicians," Dr Sotile said. "These are survival skills for physicians, and it is foolhardy not to attend to them."

Two key interpersonal relationships — those between physician and spouse and physician and colleague — could lead to stress and burnout if they grow tense and cause the physician to suffer low self-esteem, feelings of inadequacy, dysphoria, obsessive worry, passivity, or social anxiety.

When it comes to medical marriages, the Sotiles advise physicians to give up the "myth of the balanced life."

"If you're going to be married to a physician, you're going to have a spouse who works an extraordinary amount," Dr Sotile said. "The good news is that this does not necessarily mean you're going to suffer burnout, divorce, substance abuse, or disillusionment with what you do."

Medical marriages come in three forms that are fairly equally stressful: a male physician married to a nonphysician, a female physician married to a nonphysician, or a female physician married to a male physician. Female physicians, 70% of whom marry spouses with comparable earning power, have the highest rate of divorce, Dr Sotile says. Half of female physicians marry other physicians. Only about 12% of male physicians marry women who have comparable earning power, but physician wives today lead busy lives and expect the participation of their husbands at home more than past generations.

In a two-physician marriage, the spouses have more compassion for each other's love of medicine and the demands it places on their lives. "But the risk is that there will not be a stress absorber in those marriages because both members are working very hard and tend to pull toward their traditional roles," Dr Sotile said. Research suggests that in about 80% of the two-physician marriages, the woman still assumes primary responsibility for running the home — even when she makes more money than her husband — which creates a tremendous stress overload for her, Dr Sotile adds.

Once the work-family struggles have been hammered out, physicians must alleviate intergenerational tensions among colleagues in their medical groups. The new generation of physicians views the baby boomers as "a bunch of workaholics," Dr Sotile said. Some practices have three generations of physicians, including the 60-something doctor, the 40-something doctor, and the 30-something doctor who never experienced managed care's stripping away of control from physicians. Physician leaders are recognizing that the new generation of doctors is willing to take pay cuts to work fewer hours, and these leaders are encouraging the same practice in older physicians to avoid stress and burnout.

"None of the research suggests that physician burnout relates to hours worked, practice specialty, managed care, or governmental interference with the practice of medicine."

According to 20 years of research on violence in the workplace, breakdowns in interpersonal relationships at home are more likely to affect work attitudes than vice versa. "My own sense is that the physicians are very dependent on their families, but they don't acknowledge it or let the family know how important it is," Dr Nace said.

Dr Nace encourages his patients to schedule their time off and write vacations in their calendars rather than wait for opportune times to take breaks from work.

And Dr Sotile says physicians need to get rid of the "conspiracy of silence and admit that they are stressed" (see "The Conspiracy of Silence," Forum on Ethics, pp 30-32).

We can be heroes

"Physicians are the heroes," Dr Sotile said. "They are extraordinary people. They are more intelligent than most people, they're able to work harder than 98% of the people in the history of the world, and they do stuff that's more important than most people even dream of doing. Why would they settle for a half-baked life? In order to have the whole package, they've got to take care of themselves and take care of each other."

Dr Nace says that physicians should pause to appreciate their accomplishments — educationally, professionally, and in other areas of their lives — as well as the potential impact they have on every patient they see. "They need to feel positive that they're really forwarding people's health and quality of life."

Physicians also should realize that lack of illness is not the same as health and happiness, Dr Sotile says. He thinks this may be happening already as evidenced by the increase in requests for programs similar to the one the Sotiles will present at TexMed '99. "Physicians show up in record numbers to hear messages of this sort and stay overtime, whether it's grand rounds or a conference." ★

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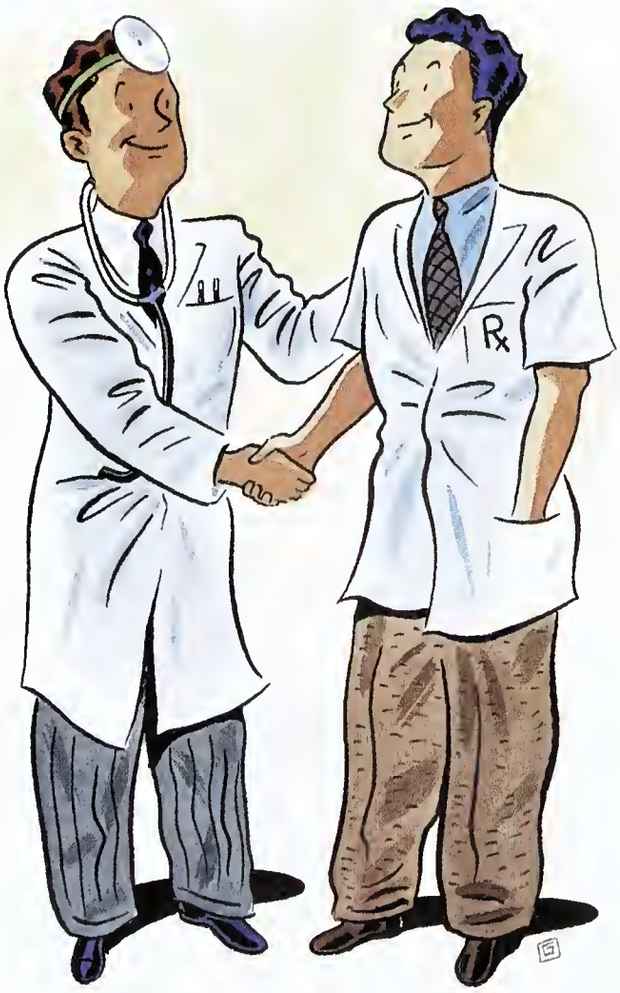
Prescription for cooperation

Texas physicians, pharmacists work collaboratively to avoid legislative battles



AJ Garces

In 1998, pharmacists and physicians in several states clashed over issues before their state legislatures. Those issues mainly involved efforts by pharmacists to redefine their role in the health care delivery system and to assume greater responsibility in providing patient care.

Those same issues will confront Texas pharmacists and physicians during the 1999 session of the Texas Legislature. But the debate likely will not be as heated as it has been in other state legislatures thanks to efforts by both professions to iron out their differences in advance. And, doctors and pharmacists likely will collaborate on several legislative issues of mutual concern that could have a dramatic impact on patient care. ➤➤

By Ken Ortolon, Associate editor

Following the 1997 legislative session, the Texas Pharmacy Association (TPA) and the Texas Medical Association appointed a liaison committee to discuss issues of mutual concern and also issues over which differences likely would arise. Both groups wanted to attempt to resolve those differences before the issues got to the 76th Legislature this year.

The committee held its first meeting in April 1998 and met twice more in 1998 to discuss the state's triplicate prescription program, managed care issues affecting both professions, and pharmacy care issues such as pharmacists giving immunizations and monitoring patient compliance with prescription drugs.

Focusing on the patient

Pleasanton family physician Leah Raye Mabry, MD, one of three TMA members who serve on the liaison committee, says the panel's focus really is on the patient. "The purpose of the committee is to improve care for our patients in Texas through both pharmacy and medicine," Dr Mabry said. "As long as we can focus away from specific pharmacy problems and specific medicine problems and work together for the patient, it makes a very good working group, and that's what we've done."

Dr Mabry and the other TMA members of the liaison committee are pharmacists as well as physicians. That gives them a unique perspective on the issues being discussed, she says. "When the pharmacists present a problem, we can evaluate that problem from a different perspective than if we were just physicians," Dr Mabry said.

Retired Giddings pharmacist Harold Pieratt, RPh, president of TPA and liaison committee cochair, says the root of the panel is a pharmacist-physician collaboration that began at least 12 years ago.

"It has been the vision of the leadership of both associations that we had more to gain by working together and that many of our adversaries were the same," Mr Pieratt said. "About 12 years ago, we came to the agreement that physicians should prescribe and pharmacists should dispense, and we've stuck to that agreement."

From that agreement grew a spirit of collaboration that has been maintained through several sessions of the legislature. Legislative disputes between Texas physicians and pharmacists have been few during that time and should be few again this year.

In fact, the work the liaison committee did in 1998 already has resulted in agreement between TMA and TPA on several issues. One of the most notable involves the state's triplicate prescription law.

Sticking with "trip scripts"

In 1997, the legislature amended the state law that requires physicians to make three copies of any prescription they write for certain controlled substances. The law requires the physician and the pharmacy to keep a copy of the prescription and the third copy to be sent to the Texas Department of Public Safety (DPS).

Under the 1997 amendments, the triplicate prescription program will be replaced on September 1 with a sticker that physicians will attach to any prescription for Schedule II controlled substances.

Neither TPA nor TMA sought the change in the triplicate prescription program, and the liaison committee has recommended the new law be phased in so that either the triplicate or single prescription pad can be used. Already, state Rep Leticia Van de Putte (D-San Antonio) has filed legislation that authorizes DPS, through its rulemaking authority, to allow either triplicate prescriptions or the stickers to be used.

"No one likes it [the sticker]," Mr Pieratt said. "The pharmacies don't like it, medicine doesn't like it, and DPS doesn't like it. The sticker program would require more information from the physician, more record keeping by the pharmacist and, therefore, it's going to cost us more."

Managing the managers

Another issue where physicians and pharmacists have reached consensus through the liaison committee is regulation of pharmacy benefit managers (PBMs). These companies administer prescription drug benefits under many managed care plans, set drug formularies for those plans, monitor physician prescribing patterns, and maintain data on individual patients.

Because PBMs have access to a huge amount of patient-specific medical information, serious concerns have arisen over how they use that information and who gains access to it through the PBM, Dr Mabry says. "We think the PBMs could lead to a serious privacy issue."

Mr Pieratt says the PBMs are compiling electronic data on prescriptions and providing or selling that data to pharmaceutical companies, insurance carriers, and others. "When drug representatives go into physician offices, they know what drugs the physician has been prescribing because of the data," he said. "Under managed care plans, when a patient signs up for an insurance program, he waives his rights, and the insurance company has the right to do whatever it wishes with that information. That's something we are going to address."

The liaison committee has recommended and will support legislation to regulate PBMs and limit activities that compromise patient privacy.

"As long as we can focus away from specific pharmacy problems and specific medicine problems and work together for the patient, it makes a very good working group, and that's what we've done."

All articles in *Texas Medicine* that mention Texas Medical Association's stance on state legislation are defined as "legislative advertising," according to Texas Govt Code Ann §305.027. That law requires disclosure of the name and address of the person who contracts with the printer to publish the legislative advertising in *Texas Medicine*: Louis J. Goodman, PhD, Executive Vice President, TMA, 401 W 15th St, Austin, TX 78701.

Agreeing to disagree

While collaboration between pharmacy and medicine in Texas remains strong, no two groups of professionals can agree on every issue. A dispute between doctors and pharmacists could arise in the area of pharmacy care.

Over the past several years, pharmacists have been taking on a greater role in direct patient care. In Washington, pharmacists are allowed to dispense birth control pills for emergency contraceptive use without a physician's prescription. In Georgia, pharmacists are taking blood pressure readings, administering immunizations, and counseling patients on medication and disease management.

Here in Texas, pharmacists with the appropriate training also have the authority to administer immunizations. And some physician practices are using pharmacists to assist in patient care by monitoring patient compliance with prescriptions and providing patient education.

The liaison committee has been monitoring these activities and will continue to evaluate their appropriateness and effectiveness. However, the decade-old agreement that physicians prescribe and pharmacists dispense could be in jeopardy over a proposal from the Texas Tech University School of Pharmacy to create a demonstration program for Type 2 diabetic patients under the Texas Medicaid program.

The Texas Health and Human Services Commission has asked the Health Care Financing Administration for a waiver to carry out the demonstration project. As proposed by Texas Tech, pharmacists in the pilot project would work under protocols with physicians. They would make physical examinations of the foot, assess appropriateness of diabetes medication regimen, make changes in that regimen that they deem appropriate, monitor prescription compliance, and provide patient education.

If the waiver were approved, Texas Tech would ask the legislature for $200,000 to fund the project.

Liaison committee member Patrick Pevoto, MD, an Austin obstetrician-gynecologist, says physicians have grave concerns over whether pharmacists have the training and skills to manage a disease as difficult as Type 2 diabetes.

"I think there are going to be a lot of doctors who are not going to be comfortable with physical examinations being done by pharmacists," he said.

TMA has undertaken a review of the Texas Tech proposal and solicited input from endocrinologists and other physician experts. TMA has received assurances from Health and Human Services Commissioner Don Gilbert that physician concerns will be taken into account before the project moves forward.

In the meantime, the liaison committee is continuing to discuss the issue and attempting to resolve differences over the proposal. Dr Pevoto says drawing a line in the sand would not be in the best interest of either profession or patients.

"The pharmacists are seeing a change in their profession," Dr Pevoto said. "I think they can see that they're not retaining enough of their best professionals. It gets to be a burnout profession when you just fill 300 or 400 prescriptions a day and you really aren't doing what you want to do, which is taking care of patients."

Dr Pevoto added that physicians "are trying to help them [pharmacists] get through this change. Instead of just getting defensive and saying that we're going to fight this project, it would be better to look at the study, see what is going to be better for the patient, and try to come to some consensus."

Mr Pieratt says pharmacists are not trying to usurp physicians' role in health care delivery but want to work with physicians in patient care. "What we are advocating is to partner with the physician, that the pharmacists simply be physician extenders, and that we would monitor and manage drug therapy under physician protocols," he said.

He realizes this is an area where the liaison committee may never reach agreement and that TMA ultimately may have to oppose the waiver and the legislative appropriation to fund the project. But that, Mr Pieratt says, is all part of the liaison process.

"We understand each other," he said. "We define our positions. We are very candid, open, and honest. We know where we stand and we know where medicine stands. That's good because we can even agree to disagree on issues.

"Explaining where we are coming from and defining our position are very important because we don't need to surprise each other on anything," Mr Pieratt continued. "I personally feel, and I think the physician members of the group feel, that we just have more to gain by working together." ★

"Under managed care plans, when a patient signs up for an insurance program, he waives his rights, and the insurance company has the right to do whatever it wishes with that information. That's something we are going to address."

War is being waged on medicine

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Publicity helps

Getting the health word out via the media can benefit your patients

An Abilene oncologist believes his patients are the real heroes because he personally has experienced their disease. What began as a profile in the *Abilene Reporter-News* about Victor Hirsch, MD, being honored by the American Cancer Society turned into a revealing look at how a physician put his patients first even when the doctor himself was suffering a life-threatening illness. ➤➤

By Laura J. Albrecht,
TMA public information officer

Putting Patients First

"I never thought that undergoing the treatment or having cancer was particularly courageous," Dr Hirsch said. "I see people everyday who are going through a lot harder times. There are so many things you aren't taught in medical school and in books. I think it does help me, in some way, be a more complete oncologist."

The article, "Doctor's Personal Experiences With Cancer Bring Special Insight Into His Practice," written by staff writer Brian Bethel, was published on October 25, 1998. Soon after, Dr Hirsch received hundreds of copies of the article, many of them from patients. Even more were clipped and delivered by the families of patients.

Dr Hirsch admits he was surprised at the public's response and "a little bit embarrassed. I got a note and copy of the article from a doctor I knew a long time ago in St Louis. It was pretty neat."

Even when he was undergoing chemotherapy at his own office, Dr Hirsch continued his practice. His nurses would have to track him down for treatment. "I would be with patients treating them but hiding from the nurses so I wouldn't have to undergo my own chemo."

In the article, Dr Hirsch said the cancer "made me a better doctor. I was extremely fortunate, and I remember what I went through every time I see a patient. I hope that my own story can inspire patients and help them understand that they don't have to succumb to this disease.

"I have been blessed with the best nurses and backup support," he said. "They are the reason I can see all the patients I do because they really enjoy what they are doing."

The article, which included a color photograph of Dr Hirsch, also described his desire to live and his understanding of what is important in life — family and friends.

"My patients are heroes, at least to me," Dr Hirsch said in the article. "And if they want to get well, I'll do whatever I can to help."

Dr Hirsch says many doctors have been told that medicine and the press don't mix. "As long as you are doing it for the right reason, then I think the press can help."

News, weather, sports, and health

Open up your local newspaper, listen to your favorite radio station, tune into the nightly news, or travel the Internet, and you will be greeted with news about your profession. Stories about medicine are hot.

"There is a hunger for medical and health information," said veteran news reporter and television news producer Bob Buckalew of Austin.

Although the media may appear to be interested only in the latest malpractice lawsuit, insurance company takeover, or physician deselection, that's not always the case.

Bad news does draw more media attention than good news. However, reporters are moving "good" health issues to the front burner. The anomaly is that medical stories can be delivered as both bad news and good news. For example, the bad news is that too many people are on the waiting list for organ transplants. The good news is more doctors are talking to their patients about being organ donors.

"We are living in an age of longer lives, concern for the well-being of our children, and medical treatment breakthroughs," said Mr Buckalew, director of the Center for Media Training in Austin. "I don't think you can have too much health and medical news. Television stations are now including health and medical news as a separate segment in their lineup of news, weather, and sports."

With reporters looking for more topics and expert sources, physicians can satisfy the overwhelming appetite for medical news by providing the information necessary to ensure a story is factual.

Who ya gonna call?

Imagine this scene. You are driving to your office one morning and hear on the radio that an outbreak of food poisoning

Quotes that strengthen patient-physician bond

Here's what a few Texas physicians said about their relationships with their patients in interviews with Texas newspapers in the past few months.

"It's just letting patients know you're a part of the world and letting them know you care, and that's part of being a physician."
Barton A. Kamen, MD, Dallas
***The Dallas Morning News*, January 9, 1999**

"Right now, I am sitting in this office and I am seeing children who are 2 months old all the way up to 92-year-old women, and I feel good about it."
Subodh Kumar Mallik, MD, Fort Stockton
***Fort Stockton Pioneer*, November 26, 1998**

"In practice, I think of myself as a geriatrician . . . preserving functional independence and preserving dignity. That's the approach I like to take."
Bruce Harrow, MD, Pampa
***Pampa News*, December 11, 1998**

"We never ask for money or if patients have insurance beforehand. If we are needed, then we do our thing first. We sort out the situation later."
Luis M. Rios, Sr, MD, McAllen
***The McAllen Monitor*, December 7, 1998**

occurred the night before at a local restaurant. All the patients have been treated and released. It just so happens that the study of foodborne illnesses is a lifelong passion and you have researched the subject extensively. When you get to the office, phone messages await you from the local newspaper, television station, and radio station. The newspaper reporter wants a phone interview. The radio reporter wants to do a live, call-in show. And the TV station wants to send a camera crew to your office.

You need to respond because, after all, you are the expert. But are you prepared?

"Doctors tend to think they are prepared for interviews because they are experts," said Merrie Spaeth, who heads Spaeth Communications, Inc, a Dallas-based communication training and consulting firm. "They are not prepared."

As the daughter, granddaughter, and niece of physicians, Ms Spaeth urges members of the medical profession to seek training in media techniques and presentations skills. "Get the training now before you need it."

Ms Spaeth says doctors would be horrified if they knew what patients and their families actually remember from their conversations. When talking to their patients and to the media, physicians have a tendency to provide too much information, be too technical, and talk too fast in terms only their colleagues would comprehend.

So why should doctors talk to reporters?

"Your goal is to educate and motivate. Doctors need to speak to the media in 'patient' terms, not medical terms."

"Your goal is to educate and motivate," Ms Spaeth said. "Doctors need to speak to the media in 'patient' terms, not medical terms."

In other words, transform your best bedside manner into a "media-side" manner. A positive story impacts not only the individual doctor but also the profession as a whole. Saying good things about colleagues proves to be a win-win situation for all involved in the profession. Ms Spaeth adds that plenty of reporters and others are prepared to bring attention to less-than-perfect physicians.

Remember, your patients are reading and listening to what you are saying.

"I think doctors could do a lot more to promote their profession," Ms Spaeth said. "You are never in the media just once. The object is to approach the media with this idea: whom do I want to show this to? Articles in the media are the best patient-recruiting tools you have other than patient referrals."

Friend, foe, or somewhere in between

The relationship physicians develop with the media in their communities varies from market to market.

Guidelines for spreading the good word

The Texas Medical Association Media and Public Relations Department encourages physicians to consider the following points when dealing with reporters:

1. **Respond promptly. The reporter often is on deadline when he or she calls. Try and return the call as quickly as possible. If your schedule doesn't allow for a quick response, let the reporter know and find a time that is convenient for both of you.**
2. **The reporter may be a veteran health reporter or a recent graduate. Be sure to provide the important facts first. Keep your response simple, but not necessarily short. If you have written material that may be helpful, offer to fax it to the reporter.**
3. **Relax and stay calm. The reporter may ask unfavorable questions. Answer questions directly and don't repeat inaccurate or offensive words.**
4. **Be honest and straightforward. Welcome the reporter and his or her questions.**
5. **You never know how a story will appear in print or on the nightly newscast.**
6. **Assume everything you say is on the record and fair game.**
7. **If you don't understand a reporter's question, ask him or her to repeat it. If you don't know the answer, assure the reporter you will find an answer to the question or provide an appropriate source.**
8. **Don't say, "No comment." Always respond to a question.**
9. **Let the reporter know you appreciate the call and encourage him or her to call back with more questions or for clarification.**

Call the TMA Media and Public Relations Department staff if you have any questions or comments. Ken Ortolon, the director, can be reached at (800) 880-1300, ext 1392, or (512) 370-1392; e-mail ken_o@texmed.org. Laura J. Albrecht, public information officer, can be reached at (800) 880-1300, ext 1381, or (512) 370-1381; e-mail laura_a@texmed.org.

"I would call probably 70% of the media in Texas friendly," said Mr Buckalew. "This includes the hometown newspaper, radio station, or TV station."

Physicians living in small-to-medium markets probably will experience friendlier relationships with the local media than those living in larger markets. However, larger markets tend to face greater pressure to attract more viewers, listeners, and readers because more numbers translate into more dollars from advertisers.

"Not to be too simplistic, but there is a sense on the part of journalists in the smaller markets that they are a part of their communities," Mr Buckalew said. One could argue the case that the larger the market, the more isolated reporters become from the community. The chance of a doctor running into a local reporter while grocery shopping is probably greater in the Rio Grande Valley than in the Dallas-Fort Worth area. But this is not to say Dallas or Houston doctors can't build strong contacts with the local media.

"The beauty of the media is the force of good that can come of it," Mr Buckalew said. "What the physicians of Texas say can make a difference in the lives of a lot of people. And that is extremely powerful." ★

"The beauty of the media is the force of good that can come of it. What the physicians of Texas say can make a difference in the lives of a lot of people."

Doctor, a few minutes of your time?

Media relations expert Merrie Spaeth of Spaeth Communications, Inc, in Dallas, offers these tips when dealing with the media:

- **Remember that your goal is to educate and motivate.**
- **Make sure the story you are pitching to the media is patient-oriented and timely. Ask yourself, "If I were the reporter, why would I write this story today?"**
- **Be personable and not too technical. You want to come across as highly trained and dedicated.**
- **Avoid too many numbers. Explain your point with personal anecdotes.**
- **Likability is crucial and it relates to trust.**
- **Television is power. Understanding television techniques is important even if you never intend to go near a camera.**
- **Stories get in the press because similar ones already are in the press. Provide the reporter with a local angle to a national story. If a story in *The New York Times* discusses house calls, and you make house calls in Muleshoe, let the media know about it.**
- **Ask yourself if your story impacts public health.**
- **Compliment your profession and colleagues.**
- **Reporters like health tips, eg, five things you can do to avoid a heart attack, five things you can do to lose weight.**
- **If you appear in a positive story, send copies to your patients and post it on an office bulletin board.**

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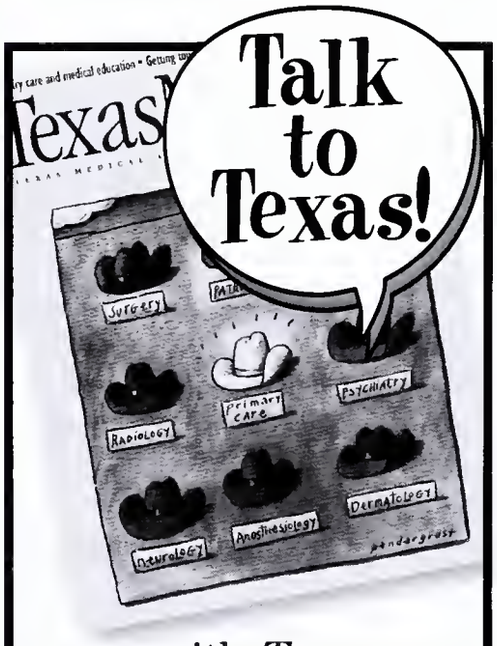

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Reuse of single-use medical devices: informed consent and physician liability

THOMAS E. COLONNA, PHD
DESENCIA E. THOMAS, MS IV

This overview addresses the controversial practice of reuse and reprocessing of single-use medical devices and the issues this practice raises for physician liability. Specifically, we describe the health risks associated with medical device reprocessing, analyze the market costs arising from the reuse and reprocessing of single-use medical devices, and discuss physician liability for failure to obtain informed consent of the patient for the use of reprocessed single-use medical devices.

Send reprint requests to Dr Colonna, 1221 Massachusetts Ave NW #611, Washington, DC 20005.

HEALTH RISKS ASSOCIATED WITH MEDICAL DEVICE REUSE

Reprocessing of single-use medical devices may adversely impact medical device performance. For example, the physical act of disassembling, cleaning, and manipulating the single-use medical device during reprocessing may adversely affect the device's safety or effectiveness. In addition, selecting an inappropriate sterilization method may damage some types of single-use medical devices or materials. These devices often are made of the cheapest suitable material, and these materials are not tested for their ability to withstand reprocessing even once, let alone several times. For example, certain single-use medical devices that incorporate flexible plastics cannot withstand the heat of steam sterilization (1). Improper use of steam sterilization with these devices may cause cracking of the plastic components. Similarly, radiation sterilization may damage certain optical devices by reducing the optical fiber capacity for color transmission (2). Furthermore, use of liquid chemical germicides may, in some instances, cause surface cracking or pitting, which may decrease the mechanical strength of the single-use medical device and make it more difficult to clean (3–5).

Moreover, even if an appropriate sterilization method is selected, bacterial contamination may result from inadequate cleaning, disinfection, or sterilization of the single-use medical device (6). In the case of reprocessed hemodialyzers, for example, numerous outbreaks of bacterial infections have been attributed to use of overdiluted chemical sterilization agents (7). In one situation, the outbreak resulted in the deaths of 15 patients treated at a single dialysis center (7). Insufficient disinfection of reprocessed hemodialysis equipment has been linked also to transmission of the human immunodeficiency virus in several foreign countries (8,9).

The level of sterility achieved with a given sterilization cycle depends on the number of microorganisms present at the start of the cycle ("bioburden") and the rate of killing, so the sterility assurance for a contaminated item is less than that for a clean item. The effectiveness of methods such as ethylene oxide and low-temperature steam formaldehyde sterilization depends very much on the correct conditions being attained in the sterilizer and on the suitability of the packaging material (10). These conditions vary with the type of sterilization equipment. Doubt exists about whether all the stages of reprocessing can be controlled and validated to the standards achieved by the original manufacturer, especially when the starting point is an unknown bioburden and when changing loads demand revalidation after each sterilization cycle.

Furthermore, while inadequate sterilization of reprocessed single-use medical devices may result in bacterial or viral contamination, use of excessively concentrated cleaning agents also may have serious health effects. For example, many medical device reprocessors use formaldehyde, a known carcinogen, for disinfection. Underdilution of the sterilization solution may leave residual formaldehyde on the reprocessed medical device, which then may be infused into the patient's bloodstream (3).

The reuse of single-use medical devices also raises occupational safety and health concerns for the health care workers engaged in reprocessing. Reuse may increase the exposure of health care workers to bloodborne pathogens and/or various toxic chemicals used for disinfection and sterilization. New opportunities for injury and exposure may arise in the reprocessing of single-use medical devices that are not intended to be han-

dled. Failure to exercise due care with respect to the employees engaged in reprocessing may, therefore, also expose hospitals to liability, as the hospitals owe a duty to their employees to provide a reasonably safe work environment. The Occupational Safety and Health Act (OSHA) requires that employers provide workers with a place of employment free from any and all hazards likely to cause serious injury or death (11). Failure to comply with OSHA may thus be used as evidence of negligence per se. Health care facilities that reprocess reusable devices should have in place policies and procedures to protect the workers who clean, sterilize, or disinfect the devices. Because single-use medical devices are not necessarily designed to be reprocessed, the act of disassembling a medical device not intended for reuse may put the worker at risk (eg, forceful disassembly may aerosolize an infectious agent or dislodge a small, sharp piece of the medical device).

To ensure safe and effective reprocessing and to protect patients and users from failures of reprocessed medical devices, the maximum number of reprocessing cycles must be determined (2,12). The reprocessor should be able to identify deterioration signaling the need to discard the medical device before it is reused (13). Compared with reprocessing of medical devices that are designed and intended for reuse, however, reprocessing of single-use medical devices presents greater difficulty in this respect because these devices are not designed to incorporate any mechanism for signaling deterioration (13).

The Food and Drug Administration (FDA) has noted the impact of medical device design on successful reuse and reprocessing. For example, the agency has stated that, "[a]s a rule, a reusable medical device should be designed so that it can be adequately cleaned. If a medical device cannot be adequately cleaned, any subsequent disinfection or sterilization process may not achieve the desired result" (13). For these reasons, some foreign health authorities have banned or disapproved the practice of reprocessing single-use medical devices (14).

In addition, when the FDA commissioned the California Department of Health Services to survey dialysis centers' reprocessing practices, the study found that reprocessing often was not executed in a controlled fashion:

> All dialysis facilities appeared to be satisfied that they were providing safe and effective reprocessed dialyzers. . . . However, the observation that facilities are frequently not adhering to their protocols, and the general lack of quality control and assurance procedures indicates that at least some of the reuse programs are not operating in a state of control (7).

The fact that regulatory and standard-setting agencies do not prohibit reuse of single-use medical devices may suggest that the practice is safe, but few studies exist on the safety of reusing disposable medical devices. Despite fears that reuse may be hazardous, little work has been done to assess safety, except in the case of hemodialyzers (15) and plastic insulin syringes (16), where the morbidity associated with reuse has been low.

FINANCIAL INCENTIVES FOR MEDICAL DEVICE REUSE

In recent years, health care professionals increasingly have become concerned with the economic issues of patient care. Among the most controversial issues is the practice of reprocessing single-use medical devices. Some hospitals believe that if disposable medical devices save money, reusing the disposable medical devices several times will save even more money.

A survey of 1238 Canadian hospitals and limited surveys in Britain and in the United States suggest that more than 40% of institutions reuse medical devices intended for single-use only (17). Several arguments have been made for the reuse of single-use medical devices: lower inventory costs, the problem of unreliable deliveries of medical devices, and reduction of the vast space taken up by stocks of single-use medical devices. However, the related costs for reprocessing, quality assurance, storage, liability insurance, and possible lawsuits should adverse effects occur make cost savings uncertain. In light of the significant risk of device impairment through inappropriate or inadequate reprocessing, the practice of reprocessing medical devices that are intended by the original manufacturer for single-use presents considerable exposure to liability.

LIABILITY FOR FAILURE TO OBTAIN INFORMED CONSENT

The duty to obtain informed consent rests generally with the physician. A few jurisdictions, however, have extended the duty to hospitals. We have found no published cases that establish whether a need exists for informed consent to reuse single-use medical devices. Whether a health care provider must disclose medical device reprocessing will depend, in part, on the nature of the risk and whether the reuse is part of a research study. For example, for hemodialyzers, the Health Care Financing Administration (HCFA) regulations require disclosure of reuse (18). If reuse is undertaken as research rather than as routine diagnosis or therapy, then hospitals should require that physicians inform their patients about the innovative nature of the reuse, including the attendant harms and benefits, and obtain explicit prior informed consent (19). Even if risks are minimal, obtaining informed consent to reuse disposable medical devices is an impor-

tant safeguard consistent with current research practices (20). Clinical trials of reuse should be performed in accordance with applicable state and federal legislation and regulations that require informed consent from the participant. Both the Department of Health and Human Services (HHS) and the FDA require that human research subjects give their informed consent and that consent be documented (21). HHS and FDA regulations set forth specific elements that must be covered in the informed consent process.

For nonresearch purposes, the need to obtain consent for use of reprocessed medical devices should be evaluated on the basis of the scope of disclosure required by the informed consent law in the jurisdiction. The patient's right to be informed of medical device reuse depends, in part, on whether the jurisdiction has adopted a patient-based or physician-based standard for the scope of disclosure, as discussed below.

POTENTIAL LIABILITY OF INDIVIDUAL PHYSICIANS FOR FAILURE TO DISCLOSE REUSE

Physician exposure to liability for reuse of single-use medical devices would most likely rest on theories of malpractice, vicarious liability, or failure to obtain informed consent. For example, a malpractice suit may allege that by permitting reuse, the physician violated reasonable standards of medical practice. This would likely involve an analysis of the weight that would be given to a departure from the medical device's labeling that states "single use only" (22). For example, if labeling a medical device for "single use only" is a viable condition of sale, and if the restriction is within the scope of the patent or was otherwise reasonable, then use of a patented product beyond the scope of the limitation could constitute infringement (22). Under the "captain of the ship" doctrine or other vicarious liability theories, physicians may be held liable also for the actions of employees under their supervision.

In litigation, the evidentiary value of the "single use only" label is likely to be called into question. Although we have found no cases that directly address reuse of single-use medical devices, several cases do involve other types of deviations from manufacturer recommendations and "off-label" use of drugs and medical devices. Reuse of a medical device labeled for single use is an example of using a device in a manner that does not appear in the device's FDA-approved labeling and is not approved by the FDA, a practice commonly referred to as "off-label," "unapproved," "unlabeled," or "extra-label" use. However, the medical device's labeling, the manufacturer's recommendation, and the FDA status of the device are likely to have an impact on the outcome of a malpractice case alleging improper reuse of a single-use medical device. In effect, the provider will need to demonstrate why the off-label use was reasonable.

The courts have taken differing approaches on the evidentiary value of package insert labeling. Some have ruled that the package insert, standing alone, does not conclusively establish a standard of care and thus does not obviate the need for expert testimony (23,24). Departure from the directions for use may not be dispositive of negligence, although the insert may be admitted as evidence of the standard of care.

Physicians also may be exposed to liability for failure to disclose reuse to patients. The physician-based standard for disclosure is premised on the physician's duty to communicate relevant information about a proposed treatment to the patient. Under the physician-based standard of disclosure, the medical community establishes the standard for whether reused and single-use medical devices should be offered as alternative treatments to the patient. For most reused medical devices, with the possible exception of hemodialyzers, the medical community probably has not adopted a standard of disclosure on reuse. Under the standard for patient-based informed consent, patients should have the right to choose between a reused medical device and a single-use medical device if reuse in fact presents a significantly different material risk to the patient. The materiality of the risks would depend on the scientific evidence as well as the quality of the facility's sterilization and decontamination practices.

Thus, the need to disclose reuse would depend on the specific medical device, the known scientific evidence, and whether reuse would pose a greater risk than the alternatives (initial use of a single-use medical device or use of a reusable medical device). The need to disclose reuse would depend also on whether the physician or health care organization follows reuse protocols to ensure that no significant increase in risk is placed on the patient. If this is the case, the physician or health care organization is unlikely to be liable for failure to disclose that a single-use medical device was reused. This assumes that the facility would not reuse a medical device in a situation where there were materially increased risks associated with the reuse.

CONCLUSION AND RECOMMENDATIONS

Rising health care costs have prompted hospitals to turn to reprocessing and reuse of single-use medical devices as a cost-saving measure. The safety, efficacy, and cost benefit of such practices are largely unknown. With the rising pressure for containment of health care costs, the practice of reuse of single-use medical devices probably will expand further.

Various legal theories provide a basis for recovery for patient injury caused by the reuse of single-use medical devices. For example, a malpractice action alleging negligent treatment or the failure to obtain informed consent could be brought against a health care organization, physician, or other treatment provider. If reuse is undertaken as research rather than as routine diagnosis or therapy, then hospitals should require that physicians inform their patients about the innovative nature of the reuse, including the attendant harms and benefits, and obtain explicit prior informed consent. Under the standard for patient-based informed consent, patients should have the right to choose between a reused medical device and a single-use medical device if reuse in fact presents a significantly different material risk to the patient. The materiality of the risks would depend on the scientific evidence as well as the quality of the facility's sterilization and decontamination practices. The risks and costs of reuse of single-use medical devices have to be determined accurately and balanced against possible financial benefits and costs.

Finally, standardized guidelines and protocols for cleaning and sterilizing, criteria for determining numbers of reuses, and complete cost-benefit analyses need to be completed. Until the necessary well-designed and controlled clinical studies are performed, the reuse and reprocessing of single-use medical devices will remain controversial.

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Abuse of Hispanic elders

MAX E. OTINIANO, MD
CARLOS R. HERRERA, MD, MPH

The nature, extent, and consequences of Hispanic elder abuse are described infrequently and often underconsidered. We reviewed information of 16,677 Hispanic elders living in the community who were abused between 1991 and 1995; these were based on valid cases reported to the Adult Protective Services (APS) office in Texas. Data did not include nursing home victims. Hispanic elders accounted for 20.6% of all elderly cases reported to APS. A 10% to 20% annual increase was seen over each of the past 5 years. Self-neglect was the most commonly identified form of abuse (63.2%). Cases with more than 1 allegation were common. The most common perpetrators (excluding self) were adult children (44.6%). Women were twice as likely as men to suffer abuse of any kind. Reluctance of victims to become involved in services to ameliorate their situations is a major barrier to effective intervention. Strategies to prevent abuse of Hispanic elders are needed and should focus on known characteristics of the abused and abusers.

Dr Otiniano, senior research assistant, Department of Internal Medicine; and Dr Herrera, assistant professor of internal medicine, The University of Texas-Houston Medical School, Houston, Tex. Send reprint requests to Dr Otiniano, Department of Internal Medicine, UT-Houston Medical School, 6431 Fannin St, Room 1.122, Houston, TX 77030.

INTRODUCTION

The population of Hispanics in the United States has increased dramatically. Projections indicate that this ethnic group will become the majority ethnic group by the year 2000 (1). In 1995, Hispanics constituted 28.1% of the Texas population. Between 1.5 and 2 million older adults are estimated to experience abuse or neglect each year in the United States (2–4); however, reliable data for ethnic subgroups are not widely available.

Targeted research is needed to determine the extent, nature, and consequence of elder abuse by state and ethnic group as appropriate social services are largely state based. Development of prevention opportunities and of more valid and reliable measures of elder abuse is needed also (5).

Although elder abuse and neglect have presumably occurred in all ethnic groups for centuries, they are the most recent forms of family violence to come to the attention of modern society. Case reports of elder abuse first appeared in the literature 20 years ago (6), but few articles relating to Hispanic elderly abuse have been published. The number of scientific investigations on elder abuse has been minimal, particularly if compared with the number of studies on child abuse in the same period. Most of the existing knowledge about elder abuse is based on small studies, nonrepresentative samples, informal surveys, and personal observations (7).

Abuse of the elderly can be divided into 4 categories:

- *Abuse* includes acts of willful infliction of injury, unreasonable confinement, or cruel punishment. The most common violent acts toward elderly persons include slapping, hitting, and striking with objects. Frequent results of such mistreatment are scratches, welts, scalp injury, bruises, cuts, sprains, abrasions, and occasionally skeletal fracture, burns, and other wounds. Other forms of abuse are rape, sexual abuse, and verbal and psychological abuse (which include the threat of abandonment or institutionalization).
- *Exploitation* or misappropriation of money or property includes illegally or improperly using the resources of an elderly or disabled person for monetary personal benefit. Examples include the theft of Social Security or pension checks, abusing joint checking accounts, the use of threat to enforce the signing or changing of wills or other legal documents, and coercion in any financial matter.
- *Neglect by caretaker* is the failure of a designated caregiver to meet the needs of a dependent elderly person. This generally is accepted as a form of maltreatment. Neglect may be intentional, as when a caregiver deliberately fails to fulfill caretaking responsibilities to harm or punish the elderly person (ie, willfully withholding food or medication), or it may be unintentional, stemming either from ignorance or from a genuine inability to provide care.
- *Self-neglect* is failure to provide for oneself the goods or services that are necessary to avoid physical harm, mental anguish, or mental illness. Examples are malnourishment; over/undermedication; lack of heat, running water, and electricity; unsanitary living conditions; and refusal of medical care, personal hygiene, or clothes.

Elder abuse cannot be assessed quickly and often presents as a cluster of signs and symptoms. Indicators used for detection of abuse include a pattern of "health care hopping," a series of missed appointments, previous unex-

plained injuries or burns in unusual locations, presence of old and new bruises, poor personal hygiene, sexually transmitted disease, extreme mood changes, depression, fearfulness, and overconcern with health care costs (8).

We would expect language problems, misinformation, and legal aspects (undocumented persons) to lead to underreporting of abuse in non-English speaking people. An elderly victim may be embarrassed or intimidated into not reporting abuse by a family member, or the victim may fear that reporting abuse will result in being placed in a long-term care facility. Elder abuse requires a certain amount of investigation because the victim often is unlikely to volunteer information. An elderly person's history should be obtained from several sources, and the findings on a physical examination may be the first clues to abuse or to suspicions about abuse or neglect.

Known characteristics of an elderly person at high risk of abuse are sex, age, dependency, alcohol abuse, past abuse, stoicism, isolation, impairment, provocative behavior, living with family, deterioration, lack of outside support, and recent stressful events in the life of the victim or the abuser (9–12). This report represents the first step of a large research effort to determine the relative importance of ethnicity in elder abuse.

METHODS

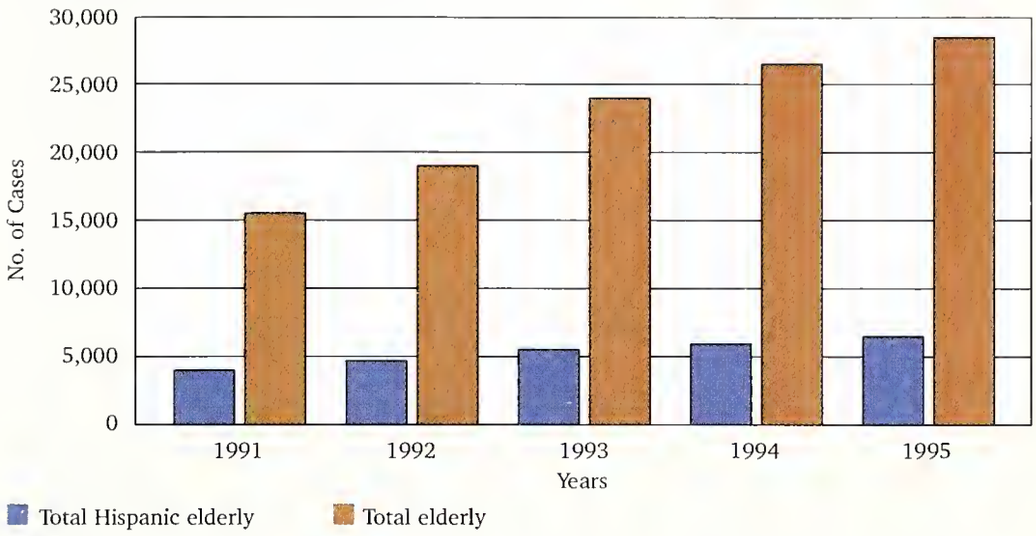
A chief impediment to rigorous epidemiologic research has been the difficulty in getting adequate information regarding abuse cases. Other impediments include the controversy about definitions, lack of racial data in abuse reports, and general limitation of retrospective study design. Determining the specific cause of Hispanic elder abuse is difficult, particularly with the limited knowledge base that now exists.

We requested from the Adult Protective Services (APS) office in Texas pertinent information regarding Hispanic elderly who were abused. Statistical records from 1991 to 1995 were reviewed to determine the incidence of Hispanic elderly abuse. The data include only those who are living in the community (ie, not institutionalized).

The information is based on state fiscal years that run September 1 through August 31. The information includes the percentage of cases, gender, type of abuse that occurred, and the relationship or name of the person or agency reporting the maltreatment. The state database does not contain information regarding the causes of abuse or the outcome of the incident.

Data were tabulated and analyzed descriptively by year. The specific type of maltreatment, identity of the perpetrator, and place of abuse are reported by each client as well as by overall frequency (multiple incidents per client).

Fig 1. Investigations of cases of abused elders, by year.



RESULTS

Hispanic elders accounted for 20.6% of all cases of elderly abuse reported to APS. The number increased annually by 10% to 20% each year during 1991-1995 (Fig 1). Women were twice as likely as men to suffer abuse of any kind.

The characteristics of Hispanic elder abuse in 1995 were compiled from reports of unduplicated complete or valid cases and an analysis of total reports (Table 1). Most cases have multiple allegations occurring in the same family. This suggests that for many, the abuse is multifactorial and chronic. A comparison of total reports to reports by client reveals the magnitude of multiple types of maltreatment occurring simultaneously. The types of abuse that occur frequently are self-neglect, followed by caretaker neglect, abuse, and exploitation. The most common perpetrators are adult children, followed by the spouses. The abuse occurred most commonly in circumstances where the elder was living with others. The most common reporter was the community, followed by family members, who have increased their participation in reporting cases of elderly abuse (Table 2).

DISCUSSION

This project has important implications for the community. Knowledge will help to educate the family and community and to prevent abuse. One major bar-

Table 1. Characteristics of abuse in Hispanic elders, 1995.

Investigation Category	Analysis by Total Reports No.	(%)	Analysis by Client No.	(%)	Reports Per Client
Type of Maltreatment					
Self-neglect	4789	(63.2)	3143	(68.1)	1.52
Caretaker neglect	1501	(19.8)	829	(17.9)	1.81
Abuse	822	(10.8)	383	(8.3)	2.14
Exploitation	455	(6.0)	254	(5.5)	1.79
Total	7567		4609		
Perpetrator					
Adult child	1624	(44.6)	1058	(22.9)	1.53
Spouse	440	(12.0)	308	(6.6)	1.42
Other	438	(12.0)	294	(6.3)	1.48
Grandchild	312	(8.5)	196	(4.2)	1.59
Other relative	305	(8.3)	171	(3.7)	1.78
Unknown	252	(6.9)	169	(3.6)	1.49
Sibling	122	(3.3)	71	(1.5)	1.71
Service provider	119	(3.2)	57	(1.2)	2.08
Friend	29	(0.8)	22	(0.4)	1.31
Code missing	0		2263	(49.1)	
Total	3641		4609		
Place of Abuse					
With others	1942	(53.3)	2175	(47.1)	0.89
Living alone	700	(19.2)	1527	(33.1)	0.45
With caretaker	778	(21.4)	661	(14.3)	1.17
Other	83	(2.3)	99	(2.1)	0.83
Institution	67	(1.8)	61	(1.3)	1.09
Homeless	23	(0.6)	45	(0.9)	0.51
Supervised	33	(0.9)	25	(0.5)	1.32
Room and board	15	(0.4)	16	(0.3)	0.93
Total	3641		4609		

Table 2. Source of reported cases of abuse in Hispanic elders, in percent.

	1991	1992	1993	1994	1995
Community	20.4	20.8	23.5	26.1	30.4
Family	21.3	20.7	20.7	22.3	20.5
Hospital	11.7	11.2	9.3	9.4	9.7
Human services	11.6	12.1	9.7	7.8	7.2
Other	7.1	7.7	6.9	6.1	6.4
Anonymous	5.5	5.7	6.4	4.5	3.5
Medical	4.5	4.0	6.3	6.1	4.6
Friend	4.4	3.6	3.5	3.5	3.8

rier to effective intervention is the lack of procedures available for case detection. APS relies on community reporting to identify cases of abuse. The number of reported cases is suspected to be only a fraction of the true prevalence rate in Texas, but the reporter is playing a critical role in preventing elder abuse. Facts about the prevalence and nature of Hispanic elder abuse have been hard to obtain. The elderly often refuse help because they fear nursing home placement and are reluctant to admit they are growing dependent on others. One reason they refuse help is the lack of training in elderly services personnel (home heath or hospital staff). Elders who refuse help should be seen by workers who have experience in dealing with these refusals. A positive development in addressing elder abuse is the use of multidisciplinary teams in hospitals or communities (13). Specialists can help to develop an appropriate intervention plan. The diagnosis, management, and prevention of elder abuse and neglect should involve a team of well-coordinated professionals from nursing, social services, and many other disciplines.

Elder abuse and neglect that result from long-standing traits of the abuser are unlikely to be improved through such interventions, even if the level of impairment in the patient is substantial (14). Inflicting serious bodily injury to a person who is 65 years or older is a criminal offense in Texas (15). In fact, only 5.7% of the average state's budget for the biennium 1996–1997 was spent on protective services for the elderly.

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Tarasoff in Texas

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Texas physicians do not have a statutory duty to warn potential victims of their patients' violent conduct but may warn medical or law enforcement authorities if the patient is a danger to himself, to the treating physician, or to others. Moreover, the Medical Practice Act of Texas does not authorize even permissive exceptions to confidentiality, thereby preventing physicians from legally warning victims. Nonetheless, 5 Texas appellate courts already have addressed a clinician's duty to issue protective warnings to reasonably identifiable victims. The approaches of these 5 courts have been similar, but important differences warrant attention. In 1998, the Supreme Court of Texas, in a fact-specific decision, did not adopt a duty for physicians to protect third persons from their patients' violent acts. All Texas physicians should become familiar with the emerging jurisprudence of professional protective responsibilities and liabilities to third persons who can be harmed physically by their patients' violent conduct.

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For more than 20 years, *Tarasoff* has been, for mental health professionals, the most widely known if not always accurately understood landmark case in mental health law, but its potential application in Texas has only recently become apparent. Five Texas appellate courts (El Paso; Austin; Houston, First Division; Fort Worth; and San Antonio, respectively) have addressed the *Tarasoff* principle, 4 of them within the last 3 years. Unlike the diverse and contradictory national jurisprudence regarding a psychotherapist's duty to warn or protect potential victims from a patient's violent acts (1,2), the approaches of the Texas appellate courts have been more similar than disparate, although some significant differences exist. Last year, the Supreme Court of Texas refused to adopt a *Tarasoff*-like duty to protect for physicians. Thus, an attempt to summarize and explain the status of *Tarasoff* in Texas is appropriate.

The facts and details of the *Tarasoff* case have been well publicized and critiqued (1,3,4). The Texas appellate courts' emphasis on a legal "duty to warn" over the broader "duty to protect" brings into focus the contrasting differences between the Supreme Court of California's 1974 *Tarasoff I* opinion (5) and its subsequent 1976 *Tarasoff II* opinion (6). In *Tarasoff I,* the California court defined the duty to warn as follows: "[W]hen a doctor or therapist, in the exercise of his professional skill and knowledge, determines, or should determine, that a warning is essential to avert danger . . . he incurs a legal obligation to give a *warning*" (emphasis added) (5). This meant that therapists in California had a legal duty to notify the identifiable victim and/or the police whenever a patient presented a foreseeable danger of seriously harming the identified person, if such warnings were the most reasonable method for averting violence.

Two years later in *Tarasoff II,* the California court vacated its first *Tarasoff* opinion and established the psychotherapist's "duty to protect":

> When a psychotherapist determines, or pursuant to the standards of his profession should determine, that the patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger. The discharge of such duty, depending on the nature of the case, may call for the therapist to warn the intended victim or others likely to apprise the victim of the danger, to notify the police, or to take whatever other steps are reasonable under the circumstances (6).

Thus, with *Tarasoff II,* warning was one of several possible protective interventions. In its 1980 decision, *Thompson v County of Alameda* (7), the Supreme Court of California set some limits on *Tarasoff*-like liability. Eventually, Thompson, too, was referenced by Texas appellate courts. In the *Thompson* case, a youth in a facility for delinquents was known to present a risk of inflicting violence and sexual abuse on young children if he were to be released. He was released, however, and within 24 hours, he allegedly sexually abused and killed a 5-year-old child. The young victim's family sued the county, claiming authorities should have made the youth's violent potential known to police, the youth's custodian, and parents in the community.

The Supreme Court of California clarified in *Thompson* that a duty to warn a victim can arise if the offender presents a "predictable threat" to a "named or readily identifiable" person, but the victim need not be specifically named for the duty to arise. This qualification, together with the *Tarasoff*

principle itself, became known as the *Tarasoff/Thompson* duty.

After *Tarasoff II,* other California cases soon demonstrated that serious and foreseeable danger could be established in litigation without verbal threats and without identifying victims by name (8,9). Concerned and uncertain about where the courts were headed with this form of expanding liability, mental health professionals turned to the California legislature. In 1985, California enacted the first protective warning disclosure statute that limited the duty to protect to situations in which the patient makes "a serious threat of violence against a reasonably identifiable victim," and the duty can be satisfied or discharged by communicating the threat to the "victim or victims and to a law enforcement agency" (10). The hope was that the statute would provide guidance and limit liability for therapists with a duty to protect third persons from the violent acts of their patients.

Three contrasting formulations applied by other, non-California courts should be mentioned because the Texas appellate courts differed in embracing one or another of these rules. First, some courts require a *specific* threat against a *specific* victim for the duty to warn or to protect to arise (11,12). Second, in one of the first cases outside of California, the Superior Court of New Jersey adopted the *Tarasoff* principle explicitly without requiring that the patient express a threat against the victim for the duty to arise, provided that the therapist knew or should have known that his patient presented "a clear danger or threat" to the intended victim (13); the victim should have been reasonably *identifiable*. Third, other courts required no threat or reasonably identifiable victim for the duty to protect to arise but only that the violence be *foreseeable* (14–16).

Several courts upheld a variant of *Tarasoff*-like liability, while explicitly refusing to invoke the special relations exception to the common law rule of nonresponsibility as the California court had done (16, 17). Another approach was to allow liability, not for harm resulting from a failure to predict violence but only after the treater actually predicted harm and then failed to take appropriate preventive action (18). The Ohio Supreme Court held that unless the treaters did not exercise professional judgment, they cannot be held liable for the violent acts of their patients; the court established a formula for determining whether professional judgment had indeed been applied (19). The Supreme Court of Michigan upheld governmental immunity for failure to protect liability where psychiatrists are employed by a state hospital (20). And, more recently, the Supreme Court of Virginia rejected *Tarasoff*-like liability regarding a patient who, though hospitalized, was controlled insufficiently to satisfy the special relationship exception to the common law rule of nonresponsibility (21). Thus, courts have not followed in lockstep the path set by the Supreme Court of California. On the contrary, the jurisprudence on a therapist's duty to protect third persons is complex and inconsistent.

TEXAS COURT OF APPEALS FOR EL PASO

Twelve years ago, in its *Williams v Sun Valley Hospital* decision (22), the Texas Court of Appeals at El Paso became the first appellate court in the state to address the *Tarasoff* principle. Mr Herrera, a patient at Sun Valley Hospital, had escaped by scaling a 7- to 10-foot wall. More than a mile away from the hospital, he leaped in front of a moving car and was killed. Ms Pamela Williams, the driver, was injured and brought suit against the hospital for allowing this patient to escape. (22)

On appeal, the Texas Court of Appeals for El Paso found no cause for liability and specifically found that the hospital had no duty to warn the driver that the patient had escaped, because the identifiability rule of *Tarasoff/Thompson* was not satisfied. The court held, "Where there is no allegation of a threat or danger to a readily identifiable person, we, like those courts whose logic we follow, are unwilling to impose a blanket liability upon all hospitals and therapists for the unpredictable conduct of their patients with a mental disorder" (22).

The El Paso court cited the trial court judge's reference to the "specific threats to specific victim's rule" in *Brady v Hopper* (11,12): "In granting a motion to dismiss on the pleadings, the court followed those cases which hold a therapist cannot be held liable for injuries inflicted upon third persons absent specific threats to a readily identifiable victim" (12). On appeal, the El Paso appellate court observed further that the appellate court in *Brady* had "noted that in *Thompson*, the court refused to extend the *Tarasoff* obligation where there were no specific threats to specifically identifiable victims" (22). Thus, although the appellate holding in *Williams* is not perfectly clear on this point, the discussion of *Tarasoff*-like liability emphasized the limited construction of the specificity rule requiring a "specific threat" as well as a specific or readily identifiable victim.

TEXAS COURT OF APPEALS FOR AUSTIN

In *Kerrville State Hospital v Clark* (23) the Texas Court of Appeals for Austin addressed the *Tarasoff* principle, even though the facts of this case did not comport with the specificity rule of *Brady*. While committed as an outpatient, an estranged husband murdered his wife. Her parents brought suit against Kerrville State Hospital and the Department of Mental Health and Mental Retarda-

tion for the wrongful death of their daughter. The verdict was in favor of the plaintiffs and the Austin appellate court affirmed, but for reasons other than a duty to warn (23). According to the trial court and the appellate court, the duty was to control the patient's aggressive behavior through the use of intramuscular medication. The plaintiffs' assumption was that the patient could not be relied upon to take antipsychotic medication on his own and he would likely become violent without medication. The Austin court stated specifically that it was not deciding "the issue of duty based on a failure to warn . . . ." The court in dicta went on to propose that a threat against a "specific victim" need not be expressed by the patient for the duty to warn to arise (23). Because the court's opinion in this matter was dicta, it is not binding upon the lower courts, and the Supreme Court of Texas in its review did not need to address it (24).

The Austin court acknowledged that the *Tarasoff* responsibility extended to a "foreseeable victim" and, citing an Arizona case, defined a foreseeable victim as "one who is said to be within the *zone of danger,* that is, subject to probable risk of the patient's violent conduct" (emphasis added) (25). Without the requirement for a threat or a specific victim, this clearly departs from the specificity rule. However, a closer reading of the Arizona court's analysis indicates that foreseeable victims are often readily identifiable either by their close proximity to the assailant, ie, living in the same household, or because of a history of threats and assaults against them in the past. Lacking further clarification on the meaning of "zone of danger," the Austin court's formulation appears to approach the foreseeability rule, which does not require a specific or reasonably foreseeable victim for the duty to apply.

The Texas Supreme Court, in a 5:4 opinion, reversed the appellate court's decision on the basis of the legal issue of sovereign immunity. The court did not address the appellate court's proposed interpretation of the *Tarasoff* principle (24) because it was dicta. Thus, the *Tarasoff*-like position of the Texas Court of Appeals for Austin remained unaddressed by the Texas Supreme Court. This court's minority opinion, however, provides some insight as to how *Tarasoff* might be analyzed in the future, pointing to the assailant as posing "a serious danger to a readily identifiable person" (24). These are terms and phrases reminiscent of the *Tarasoff/Thompson* duty.

TEXAS COURT OF APPEALS FOR HOUSTON, FIRST DIVISION

As of today, the only appellate court to affirm *Tarasoff*-like liability in a particular lawsuit is the Texas Court of Appeals for Houston, First Division, in the 1996 *Zezulka v Thapar* decision (26). Mr Lilly was described as a "mentally ill Vietnam veteran . . . who hated his stepfather, Mr Zezulka" (26). Once Mr Lilly had allegedly slapped his stepfather in public (26). Mr Lilly told his psychiatrist, Dr Thapar, that he wanted to kill his stepfather (26). During a psychiatric hospitalization in August, the medical record showed Mr Lilly was homicidal and wanted to kill his stepfather. The following month, soon after having been discharged from the hospital, Mr Lilly carried out his homicidal wish. Dr Thapar allegedly had not warned Mr Zezulka or any family member of the threats made by Mr Lilly (26). Finding that Dr Thapar had a duty to warn the victim, the Houston appellate court explained:

> We are not asked in this case to hold a doctor responsible to the general public at large. Because Thapar allegedly knew of a specific threat to a specific person, we hold that she had a duty to warn the person (26).

In the single Texas appellate case in which the facts fit a *Tarasoff*-like scenario, the court found a *Tarasoff*-like duty, at least where the more limited specificity rule was satisfied. It remains to be seen whether the Houston court also would find third-party liability where facts of a case correspond not within the narrow specificity rule but with the broader reasonable identifiability rule of *Tarasoff/Thompson* doctrine.

TEXAS COURT OF APPEALS FOR FORT WORTH

In *Kehler v Eudaly* (27), the Texas Court of Appeals for Fort Worth addressed the *Tarasoff* principle in a case in which the facts did not conform to the *Tarasoff* requirements for liability. Beginning in 1985, Mr James Bigby, an employee at Frito-Lay, was evaluated for multiple musculoskeletal and neurological complaints that were allegedly associated with a job-related injury. In 1986, he began treatment for depression with Dr Harold Eudaly, who prescribed antidepressant medication (27). On December 1, 1987, because of increasing depression, Mr Bigby was admitted to Saint Joseph Hospital, where he received electroconvulsive therapy. On December 11, after the third treatment and without being discharged, Mr Bigby left the hospital. The following day, after several attempts were made to convince Mr Bigby to return to the hospital, Dr Eudaly changed his status to "discharged." Dr Koechel, a psychologist who had been providing therapy for Mr Bigby, saw him in an office visit (27).

Eleven days after hospital discharge, on December 22, Mr Bigby killed 2 Frito-Lay employees; the next day, he killed Michael Trekell and Mr Trekell's 4-month-old son, Jayson Kehler. On both counts, Mr Bigby was convicted of capital murder, and he was sentenced to death (27).

Ms Grace Kehler, Jayson's mother

and the reported common-law wife of Mr Trekell, and Mr Trekell's parents brought suit against Mr Bigby's treaters. The principal issue of contention was whether the defendants owed a duty to the victims based on the *Tarasoff* principle, or whether, as the defendants contended, they had no duty because neither a "readily identifiable victim" nor a "foreseeable danger" existed as required for the duty to arise under *Tarasoff* doctrine. The trial court found no such duty existed in this case. The Texas Court of Appeals at Fort Worth affirmed the lower court's granting of the defendants' Motion for Summary Judgment (27).

After an extensive discussion of the Texas law regarding duties to third parties, the *Tarasoff/Thompson* rule, and its reference in Texas cases, the Texas Court of Appeals for Fort Worth clarified that neither this court nor the Texas Supreme Court had adopted a *Tarasoff*-like "duty to warn." However, the Fort Worth court commented on when protective duties might possibly arise. If a specific or readily identifiable victim is threatened, the likely protective duty is "to warn" (22,28). On the other hand, where the violence is foreseeable but without a specific or readily identifiable victim, the duty might more appropriately be to control the patient in a medically suitable manner (23).

COURT OF APPEALS OF TEXAS FOR SAN ANTONIO

In *Limon v Gonzaba* (29), the Texas Court of Appeals for San Antonio became the fifth Texas court of appeals to address the *Tarasoff* principle in a case that did not fit this legal theory. Lorenzo Limon, suffering from symptoms of depression, was brought to the Gonzaba Clinic by his daughter on February 4, 1992. She expressed the view that Mr Limon was "a danger to himself and others and needed to be in the hospital" (29). Mr Limon was concerned about an upcoming urinalysis for drug screening at work and had been bothered by telephone calls from his former wife. In his 20- to 25-minute interview with a substance abuse counselor, Mr Limon denied feeling suicidal or homicidal. He made no threats and denied ownership of a gun. Mr Limon was referred to the Alamo Mental Health Group. Only 2 days after this initial clinic visit, Mr Limon shot his former wife in her own home, leaving her paraplegic (29).

In rejecting the application of the *Tarasoff* principle to this case, the San Antonio appellate court (29) cited with agreement the Fort Worth's appellate opinion in *Kehler*:

> While it is likely a foreseeable duty would be recognized in Texas under a *Tarasoff/Thompson* fact situation with an identifiable victim, this case would nonetheless fail to fall within its parameters. Thus, each of the appellee's motion(s) for summary judgement properly responded to the appellant's only viable claim, a claim arising under *Tarasoff/Thompson* principle to elaborate on when a duty might arise. First, should the mental health treater have "foreseen that the patient would injure or kill someone"? If so, was the intended victim "identifiable, by name, or otherwise"? When these questions can be answered in the affirmative, the treaters may have a "duty to warn" (27).

SUPREME COURT OF TEXAS

In *Van Horn v Chambers* (30), the Supreme Court of Texas refused to adopt a duty for physicians to protect third persons from the violent acts of their patients, at least in reference to the facts of the case. Johnny Long, Jr, was taken to the hospital, presenting with seizures, alcohol withdrawal, and combativeness. In the neurological critical care unit, Mr Long was treated with anticonvulsant medicine and managed with leather restraints. The following day, Dr Van Horn determined that Mr Long no longer required intensive care and transferred him to a private room on a general hospital ward. The day after the transfer, Mr Long decided to leave the hospital. A medical student and 2 hospital employees tried to restrain Mr Long. In the struggle, all 4 men crashed through a barrier and fell 24 feet to a concrete floor. Mr Ronald Chambers (an employee) and the medical student died. Mr Long and Mr Johnson (another employee) survived with injuries.

Mr Johnson and Mr Chamber's representative sued Dr Van Horn. The 6 claims essentially included failure to properly diagnose the patient's condition, failure to properly treat the patient's condition, and various failures in the safe management of his potentially violent behavior. After the trial court granted summary judgment for Dr Van Horn, the court of appeals reversed, and then the Supreme Court of Texas reversed the appellate judgment.

In citing its earlier opinions, the court noted that it previously held that mental health professionals have no duty to third persons not to misdiagnose a patient's condition. The court also had held that a hospital has "no legal duty to a third party to provide competent care to [a] third party's wife or unborn child" (31).

The court observed, "In short, this is ultimately a case of injured parties other than the patient claiming that a doctor negligently misdiagnosed, and in turn negligently treated, a patient's condition. Any duty of reasonable care on Dr Van Horn's part to avoid such negligence originates solely through the relationship with, and flows only to, his patients" (30).

The Supreme Court of Texas refused to apply the "special relationship" exception to the common law nonresponsibility rule cited in *Tarasoff* and as defined in the Restatement (Second) of Torts, Section 315. Aside from the court's view that a physician-patient relationship is not "special," so as to impose a duty to control, ". . . there is nothing inherent in the relationship that gives a doctor the right to control his patient" (30). The court further rejected application of the "takes charge" exception to nonresponsibility (Restatement [Second] of Torts, Section 319) at least for physician-patient relationships, such as the one in the instant case. In support of its rejection of the special relationship exception, the court cited, in dicta within parentheses, the *Nasser* decision of the Supreme Court of Virginia, which found that even voluntary hospitalization afforded too little control of the patient to justify imposition of a duty to protect third persons.

DISCUSSION

When does a *Tarasoff*-like duty to warn/protect arise in Texas? As already seen, courts outside of Texas have shown great diversity in defining when such a duty occurs. In Texas, too, we see a range of thresholds though not as wide a range as seen on the nationwide level. Most conservatively, in upholding liability for a psychiatrist's failure to warn, the Texas Court of Appeals for Houston, First Division, applied the specificity rule in *Zezulka v Thapar* (26), and the El Paso appellate court seemed to lean towards the specificity rule in *Williams v Sun Valley Hospital* (22). Other courts favored the identifiability rule of *Tarasoff/Thompson* doctrine, providing a broader application of the duty than the specificity rule but not nearly so broad as the foreseeability rule of *Lipari* (14), *Petersen* (15), and *Schuster* (16), in which the victim need not be reasonably identifiable for the duty to arise. And finally, in *Van Horn v Chambers,* the Supreme Court of Texas raised doubt as to whether a *Tarasoff*-like duty to protect will prevail in Texas.

In defining when a victim should be considered foreseeable, even without a threat, the Austin appellate court (23) cited the Arizona Supreme Court's analysis of the "zone of danger" concept in *Hamman v County of Maricopa* (25). A person who is in the zone of danger is at risk for being violently victimized by the patient. By itself, this definition is incomplete because a person can be subject to a patient's violence without the therapist's knowledge. The mere existence of a danger does not by itself make the danger foreseeable. In *Hedlund v Superior Court of Orange County* (8), another duty-to-protect case appealed to the Supreme Court of California, the victim-mother was thought to be identifiable, but the mother's child also was considered to be a foreseeable victim because a young child can be expected to be close to its mother. In automobile accidents, persons in the zone of danger, ie, in the trajectory of the vehicle, are considered to be foreseeable victims, even if not nameable or individually identifiable by the errant driver. But this is not analogous to a therapist-patient-victim situation. The zone-of-danger concept, when applied to duty-to-warn or duty-to-protect cases, would seem to be somewhere between the identifiability rule and the foreseeability rule in *Tarasoff*-like liability cases. As of this writing, no Texas court has used a zone-of-danger analysis in considering a psychotherapist's duty to third parties. The Austin appellate court's mention of the zone of danger was a side issue placed in a footnote and, therefore, is not binding on lower courts as precedent. Clinicians in the Austin area should have a working knowledge as to what is meant by zone of danger. Unfortunately, a clear definition is missing in the opinion.

The San Antonio appellate court, though citing the Austin appellate court's reference to the "zone of danger" concept in establishing who is a foreseeable victim and whether the therapist has a duty to warn the victim, opined that with a *Tarasoff* fact pattern, Texas would use a *Tarasoff/Thompson* analysis in deciding the case.

As noted above, the Austin court cited a decision of the Supreme Court of Arizona, *Hamman v County of Maricopa* (25), in which the foreseeable victim, who is in the zone of danger, is "subject to probable risk of the patient's violent conduct" (25). However, without further qualification, this does not explain foreseeability because a potential victim can be at risk of danger from a patient without the therapist's knowledge. Perhaps, having just quoted the *Tarasoff* principle, the Arizona court meant, "When the therapist determines or under the applicable professional standards reasonably should have determined . . ." that the person is "subject to probable risk of the patient's violent conduct," then the person is in the zone of danger and should be regarded as a foreseeable victim deserving protective measures (6). But neither the Arizona court nor the Austin court said this. In any event, even this link to foreseeability would not have provided any more guidance than the *Tarasoff* principle itself. Thus, clinicians find themselves in the precarious position of having to guess what the courts mean by "zone of danger."

In *Limon v Gonzaba* (29), the San Antonio appellate court found no direct evidence from the evaluation of the patient that he was dangerous, let alone the identity of his victims. The court clarified that it had "no trouble following the philosophical underpinnings of *Tarasoff* and *Thompson*" (29). The court then provided the following analysis:

There are two elements in *Tarasoff* and *Thompson*. Both involve basic foreseeability questions. The first question is whether a reasonable health care provider could have foreseen that the patient would injure or kill someone. If a reasonable health care provider could have foreseen that harm would come to someone, then the second question arises — who is the intended victim? If the victim is identifiable, by name or otherwise, the duty to warn the intended victim arises (29).

The Austin appellate court invoked the zone-of-danger concept of *Hamman v County of Maricopa* in a footnote to establish that the victim was foreseeable: "We agree with the Clarks [plaintiffs] that under [the *Hamman* zone of danger] definition, Rebecca [the victim] was a foreseeable victim. As Gary's wife, she was certainly within the zone of danger, and she had been the victim of Gary's violence on many previous occasions" (23). Having already supported "a duty to the general public to use reasonable care in the release of Gary," the Austin court did not determine that a duty to warn actually existed in this case — only that such a duty "may have" existed (23, see footnote 13, pp 436–437). Given that Rebecca already had been assaulted and threatened by Gary, she would have known, perhaps better than the physician, the danger he posed to her safety. In this case, either hospitalization or appropriate medication may have been more protective than a warning.

In *Hamman v County of Maricopa* (25), the Arizona case cited by the Austin and San Antonio courts, facts indicated that John Carter, the patient, suffered from schizophrenia and was psychotically disturbed when his mother and stepfather brought him to the Maricopa County Hospital for evaluation (25). His parents thought he was dangerous and should be hospitalized, whereas the doctor judged him to be "harmless" (25). The court was critical of the apparent inadequacy of the evaluation. In reasoning what is the most appropriate rule for establishing whether a duty to potential victims should exist, the Arizona court reviewed the specificity rule of *Brady v Hopper* (11,12), finding this to be too narrow; the foreseeability rule of *Petersen v State* (15), comparable to *Lipari* (14); and the application of the *Tarasoff* rule in *Jablonski* (9). Finding the *Jablonski* approach to be the least extreme and most practical, the Arizona court favored this and applied the term "zone of danger." However, some differences may be found in these 2 cases. Though patient Jablonski had made no threat against his wife, his violence against her was considered foreseeable because he had raped her and violently abused her in other ways. Though John Carter's aggression was not so clearly focused on his parents, they were in the zone of danger because they lived under the same roof with John. "Their constant physical proximity to Carter placed them in an obvious zone of danger" (25). Thus, a foreseeable victim of a violent patient may be someone who is in frequent or constant physical proximity with the patient, ie, lives under the same roof or who has been the recipient of violent attacks from the patient on prior occasions.

Five Texas appellate courts have recognized a *Tarasoff*-like duty as possible, likely, or present in Texas. The Houston First Division Court, in the only case that factually comported with the *Tarasoff* principle, found a duty with corresponding liability where the specificity rule was satisfied. The other 4 courts seem to have settled on a *Tarasoff/Thompson* formula for establishing foreseeability with a corresponding duty to warn. A zone of danger (23,25) with a "probable risk of the patient's violent conduct" could lend itself to more interpretations than a simple "reasonable identity" rule.

Note that the duty to warn of the vacated *Tarasoff I* (5) decision has come to the fore in these court opinions. Correspondingly, the duty to protect of *Tarasoff II* (6), though quoted as the *Tarasoff* principle, is emphasized much less. Though the opinions are not always explicit on this point, we would assume that the person to be warned would generally be the identifiable victim, as per *Tarasoff II* (6), or someone who could in turn notify the victim or victims.

Yet, other protective duties are brought into a few of these discussions, including the duty to contain or control, traditionally meaning duty to hospitalize or to keep hospitalized a dangerous patient. However, the *Kerrville* (23) opinion raised another intriguing possibility: a duty to medicate a patient with intramuscular long-lasting antipsychotic medicine where the patient does not reliably take medicine on his own but without medicine can be expected to regress and become violent against others. Failure to properly diagnose and failure to properly treat are more common causes of psychiatric malpractice lawsuits than a failure to warn. But the claim that a failure to use intramuscular medicine can result in liability to those foreseeably harmed by the unmedicated patient is a novel, if not unreasonable, cause of action that perhaps deserves more attention than the highly publicized duty-to-warn issue. Such a duty would not relieve the physician of the responsibility of informing the patient of the benefits and risks of intramuscular medicine and alternative treatments. In Texas, a refusing patient must first be involuntarily committed and then court-ordered to take medicine in nonemergency situations.

The Supreme Court of Texas appears to have rejected a *Tarasoff*-like duty to protect. However, the court's holding should be interpreted with caution be-

cause in its entirety, the opinion is very focused on the facts of the case. The facts of *Van Horn* do not lend themselves to a traditional formulation of foreseeability upon which protective duties generally are founded. The opinion does not mention a specific threat or a foreseeable victim. Would the court find a duty to warn or protect in a case where the facts, allegations, and claims comport with the specificity rule for establishing foreseeability?

Another reason for cautious interpretation is the unanswered question of whether, given sufficient control, a physician could have a duty to protect third persons after all. In *Nasser v Parker,* a supporting citation for *Van Horn,* the Supreme Court of Virginia found even voluntary hospitalization offered insufficient control over the patient to impose a protective duty to control the patient and prevent the patient from harming third persons. Though not explicit on its point, the Virginia court left open the possibility of a protective duty to third persons when the patient was under the control of involuntary commitment. Similarly, whether the Texas court would find a duty to protect third persons when the patient is involuntarily committed was not addressed in *Van Horn.*

The Supreme Court of Texas has not determined whether a duty to protect or a duty to warn exists for psychiatrists and other health care providers in the state. And now, the court has rejected a duty to protect others from a voluntary, nonpsychiatric inpatient. Except for reporting requirements for suspected child abuse and elder abuse, no statutory duty exists to disclose protective warnings or to take other protective measures to protect third persons from physical violence a la *Tarasoff.* Despite the numerous exceptions to confidentiality, the Medical Practice Act's section on Confidentiality and Privileged Communications (32) does not allow physicians to breach confidentiality to warn an intended victim or a person or agency with protective abilities except for medical and law enforcement authorities. Even without statutory law adjusted to allow violation of confidentiality, these Texas appellate courts would probably accept the *Tarasoff* dictum: "Privileged communication (or for that matter confidentiality) ends where the public peril begins" (6).

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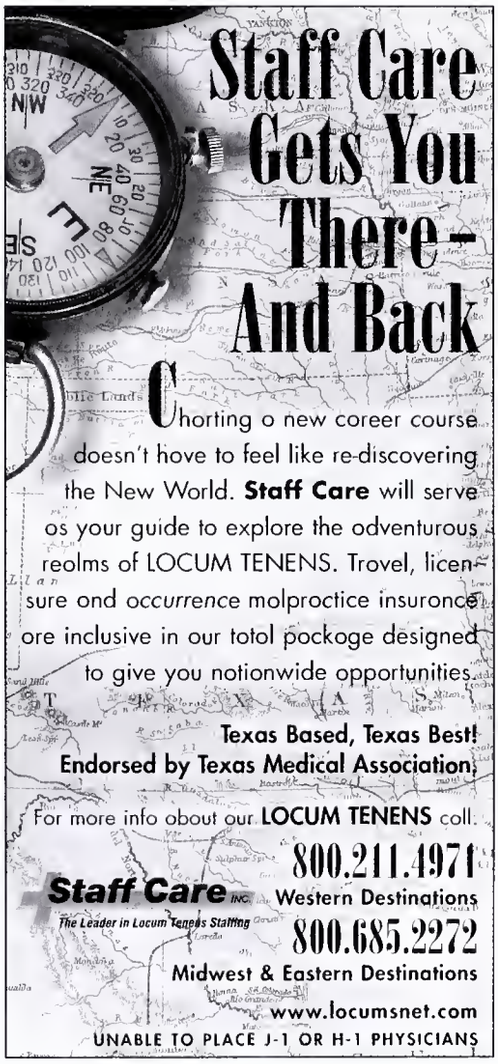

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2nd Annual Complementary and Alternative Medicine: "Scientific Perspectives and Human Needs," April 6, UT Southwestern Medical Center at Dallas, Gooch Auditorium. Course Director: Robert Gatchel, Ph.D. CME credit offered. Contact Stacey Novotny, program coordinator, (214) 648-2166.

Ambulatory Outpatient Surgery, April 10, UT Southwestern Medical Center at Dallas. Course director: Girish Joshi, MD. CME credit offered. Contact Stacy Novotny program coordinator, (214) 648-2166.

Recent Advances in HIV Medicine, April 16-17, UT Southwestern Medical Center at Dallas, Simmons Biomedical Research Building, Excellence in Education Auditorium. Course director: J.W. Smith, MD. CME credit offered. Contact: Lisa Dunlevy, program coordinator, (214) 648-2166.

Southwestern Center for Minimally Invasive Surgery: Hernia Advances in Surgery, April 22-23. UT Southwestern Medical Center at Dallas, Excellence in Education Foundation Auditorium, Simmons Biomedical Research Building. Course director: R.V. Rege, MD. CME credit offered. Contact: Leah Cannon, program coordinator, (214) 648-2166.

Current Topics in General Surgery 1999, May 6-8. UT Southwestern Medical Center at Dallas, Excellence in Education Foundation Auditorium, Simmons Biomedical Research Building. Course director: Erwin Thal, M.D. CME credit offered. Contact: Leah Cannon, program coordinator (214) 648-2166.

Southwestern Center for Minimally Invasive Surgery: Splenectomy-Laparoscopic Advances, May 8-9. UT Southwestern Medical Center at Dallas, Excellence in Education Foundation Auditorium, Simmons Biomedical Research Building. Course director: Daniel Hones, M.D. CME credit offered. Contact: Leah Cannon, program coordinator (214) 648-2166.

18th Annual Current Issues in Surgical Pathology, May 13-15. Sponsored by UT Southwestern Medical Center at Dallas. Westin Galleria Hotel, Dallas, Texas. Course director: Jorge Albores Saavedra, M.D. CME Credit offered. Contact: Jim O'Reilly, program coordinator (214) 648-2166.

Southwestern Orthopaedic Surgery Board Review, May 14-16. Sponsored by UT Southwestern Medical Center at Dallas. Wyndham Anatole Hotel, Dallas, Texas. Course directors: Richard E. Jones, M.D. and M.B. Henley, M.D. CME credit offered. Contact: Lisa Dunlevy, program coordinator (214) 648-2166.

BackTalk

Question

How do you prevent taking personal stress out on your patients?

"I think it's best to live a balanced life, to have a number of interests outside of medicine, and to have a support system to help deal with problems."

Kenneth N. Vogtsberger, MD, 48
addiction psychiatry, San Antonio

"To lessen the effects of stress, I practice what I advise my patients to do: get regular exercise; use humor to keep life's events in perspective (including sharing jokes and cartoons with my office staff when we've had a particularly stressful day); attempt to keep a regular sleep schedule; maintain a balanced diet; create more of a balance between practicing medicine and recreation by occasionally pulling away from work by means of 'minibreaks' to prevent burnout; stop to reflect on the joy of simple things in life that can help me look beyond my seemingly small scope of worries; and above all, through prayer, tap into God's endless supply of physical and spiritual strength, remembering that ultimately the reason for being a physician at all is for the people."

Kimberly M. Bethune, MD, 31
internal medicine, Lubbock

"Identify the source of stress. If it's coming from the patient, discuss it with the patient to attempt to redirect the patient toward a more constructive behavior. If the source is a third-party payer, realize it's a hazard of the job and go work out to relieve the stress."

Steve C. Opersteny, MD, 41
physical medicine and rehabilitation, College Station

"I think about their problems, not my problems. Theirs are more significant. I also decrease my number of scheduled patients. I leave my problems at my front door."

Armando C. Angel, MD, 58
rheumatology, El Paso

"Twenty-four years of practice have taught me that my personal problems pale in comparison with many of my patients' problems and illnesses. A moment of prayerful thankfulness for my many blessings relieves my stress."

William N. Elkins, Jr, MD, 56
internal medicine, Dallas

"Unfortunately, I seem to, from time to time, take it out on everyone else. The patient rarely gets it, but to those other unfortunate folks around me — I'm sorry."

John H. Calhoon, MD, 42
cardiothoracic surgery, San Antonio

"I retired."

Charles P. Cavaretta, MD, 62
rheumatology, El Paso

"The more frustrated I feel myself becoming, the harder I try to put myself in the patients' shoes."

Stacy L. Jones, MD, 40
anesthesiology, Austin

Back Talk is a nonscientific sampling of Texas physicians' opinions on a topic of interest. Physicians are polled by telephone, fax, or e-mail. We welcome suggestions for future topics. Send them to *Texas Medicine*, Back Talk, 401 W 15th St, Austin, TX 78701; fax them to (512) 370-1632; or e-mail them to m_mcever@texmed.org.

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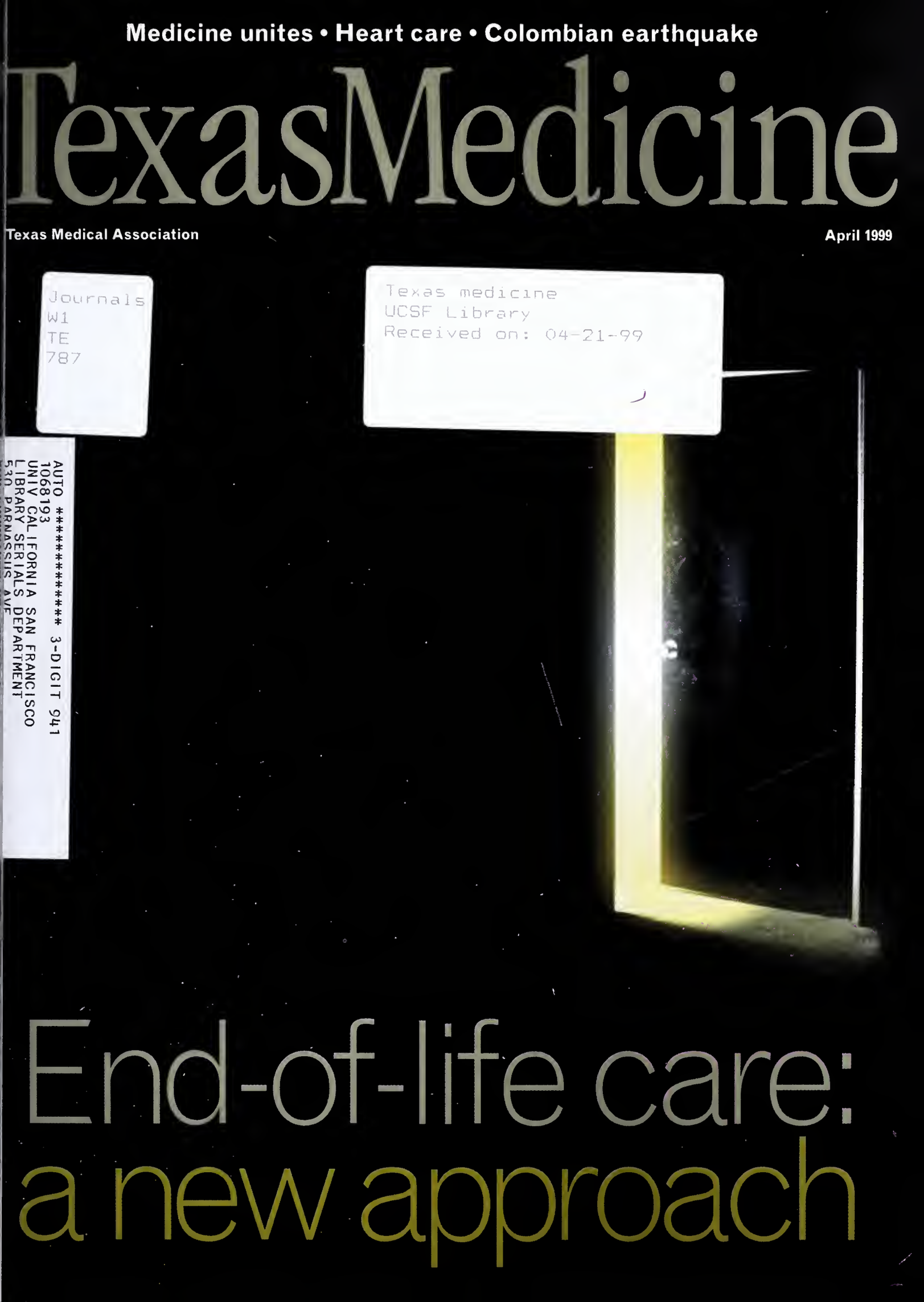

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A new approach

It may be the ultimate paradigm shift. Physicians have always been trained to prevent death at all costs, but medicine is beginning to realize that more attention should be paid to providing compassionate end-of-life care when death is inevitable. As one physician puts it, doctors aren't insensitive to their patients' needs, "they just haven't been taught how to deal with dying patients."

By Teri Moran

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Organized medicine is putting up a united front against the latest attempted encroachment into the practice of medicine by optometrists. Physicians in ophthalmology, family practice, dermatology, internal medicine, surgery, oncology, and pediatrics have joined forces against optometry's efforts in the Texas Legislature to dramatically expand its scope of practice.

By Ken Ortolon

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Cardiovascular disease, America's No. 1 killer, has a new enemy as the Texas Medical Association and the American Heart Association launch the HeartCare Partnership. Physicians now have access to a self-auditing program led by physicians that will allow them to improve their medical management of heart patients and give them the documentation to prove that what they are doing is right.

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By David Ross

Putting Patients First

Above and beyond 56

Meet four Texas physicians who routinely go the extra mile for their patients. They don't do it for money or for acclaim. They do it because it's the right thing to do.

By Sherri Deatherage Green

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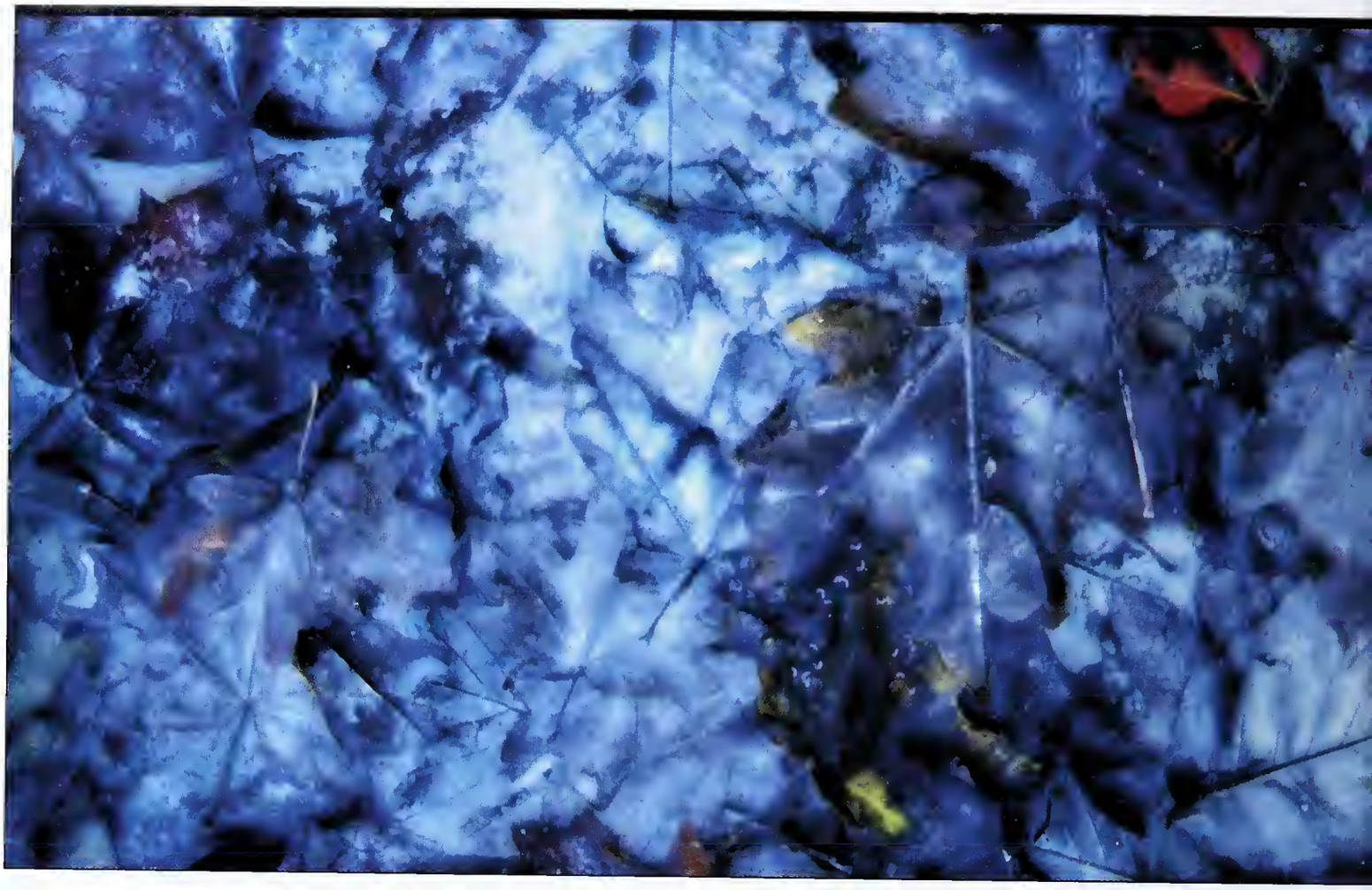

The Big Picture

Winter day at Lost Maples State Park, by Deborah Douglas, MD, San Antonio

If you would like to submit a photograph for The Big Picture, please send it to Laura J. Albrecht, Photo Editor, *Texas Medicine*, 401 W 15th St, Austin, TX 78701.

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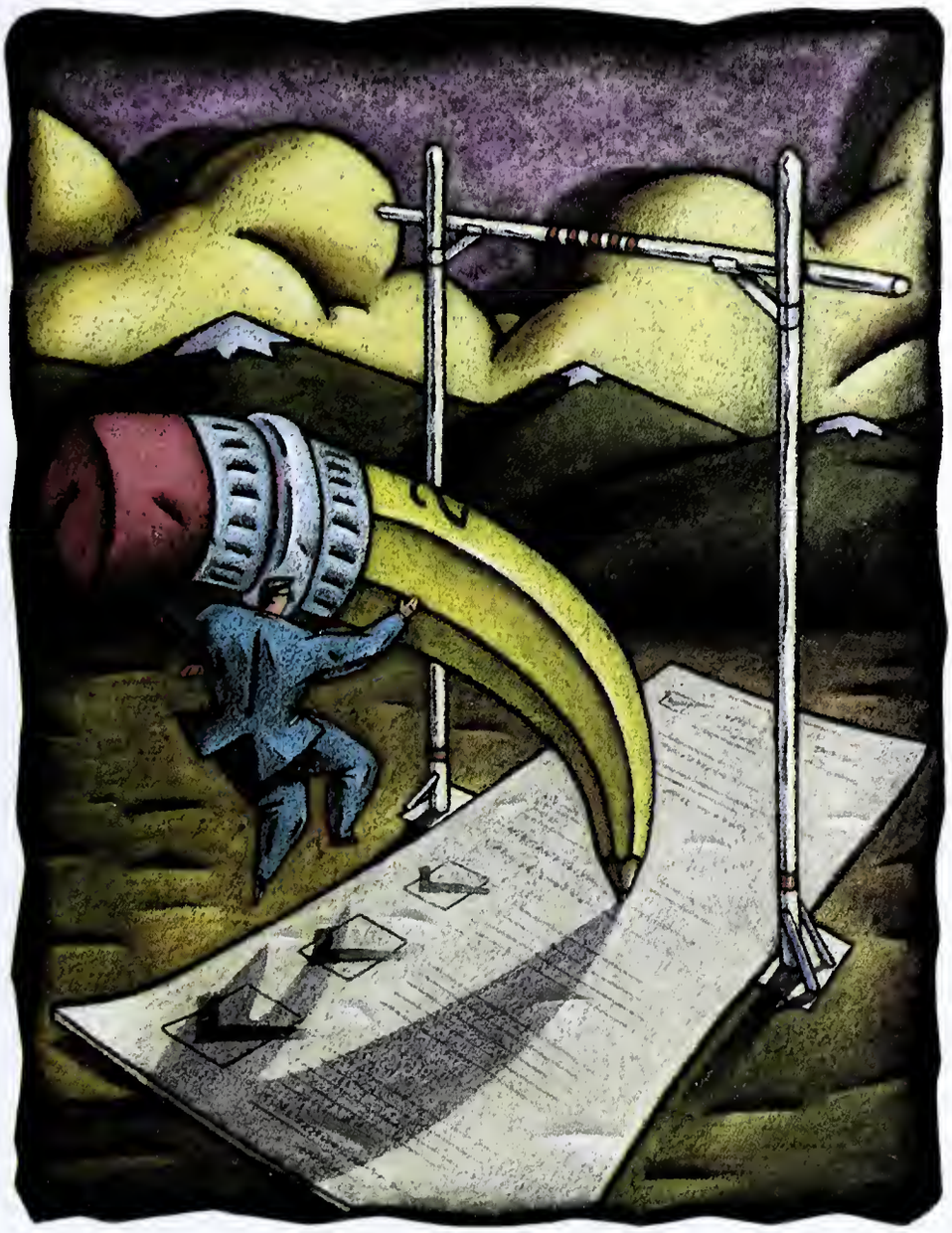

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Letters

Qualification, not diversification

Having known Dr (James) Guckian at The University of Texas Medical Branch (UTMB) and respected him as an intelligent and reasonable man, I was distressed to see him genuflecting before the false god of "Diversity." (See "After *Hopwood*," February 1999 *Texas Medicine*, pp 56–59.) He has fallen victim (as, apparently, has the Texas Medical Association) to the politically correct mantra of social liberals who believe, according to Harvard Professor Cornel West, that "we have to use race to get beyond race."

I suggest Dr Guckian read California's Proposition 209 and the words of President John F. Kennedy, to wit, "Every time we use race, ethnicity, or sex as the basis for conferring a public benefit, we inject a dose of poison into our body politic. We widen the divide that separates people of different races, beliefs, and cultures. We create a fault line potentially more destructive than any earthquake."

If Dr Guckian doubts the corrosive effect of reverse discrimination or believes the false premise that diversity produces quality, I recommend that he ask Ward Connerly, Alan Keyes, Thomas Sowell, and Walter Williams for their advice. Alas, perhaps the goal of UTMB is no longer to train the best physicians by starting with the most qualified, but, by lowering its standards to circumvent *Hopwood*, placate the small but vociferous minority who desires to abolish the meritocracy in favor of entitlements and preferences.

Larry C. Roberts, MD
High Plains Dermatology Center
4302 Wolflin
Amarillo, TX 79106

Differences in vegetative states

The February 1999 *Texas Medicine* Forum on Ethics ("Handling Coma and Brain Death," pp 26–27) discussed the importance of clear and sensitive communication with families when discussing brain death, coma, and vegetative state. As one who frequently must lead families through this maze, I sincerely endorse this goal. However, I offer some important amendments to Dr Fine's suggestions.

The phrase "eyes-open persistent coma" as a description of vegetative state only serves to further the confusion over terminology (1). Once eye-opening returns, it is no longer appropriate to refer to the state as "coma" (2). As Dr Fine noted, families often cling to that Hollywood myth of waking from coma whenever the term is used. We describe the patient in a vegetative state as "awake but not aware." Others offer the description "wakeful unconsciousness." It should be noted as well that the patient is regarded as vegetative. The qualifier "persistent" is not added until the vegetative state has "persisted" for 1 month after the injury (3).

Persistent vegetative state (PVS) is not synonymous with permanent vegetative state. Fifteen percent of adults in nontraumatic PVS regain consciousness and 52% of adults in traumatic PVS regain consciousness (3). Informed discussions regarding treatment directives should include information on probability of recovery of consciousness and functional outcome appropriate to the patient's age and etiology of injury (4).

Nancy Childs, MD
Brown Schools Rehabilitation Center
1106 W Dittmar Rd
Austin, TX 78745

References

1. Childs NL, Mercer WN, Childs HW. Accuracy of diagnosis of persistent vegetative state. *Neurology*. 1993;43:1465–67.
2. Plum F, Posner JB. *The Diagnosis of Stupor and Coma*. 3rd ed. Philadelphia, Pa: F.A. Davis; 1980.
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4. Practice parameters: assessment and management of persons in the persistent vegetative state. The Quality Standards Subcommittee of the American Academy of Neurology. *Neurology*. 1995;45:1015–1018.

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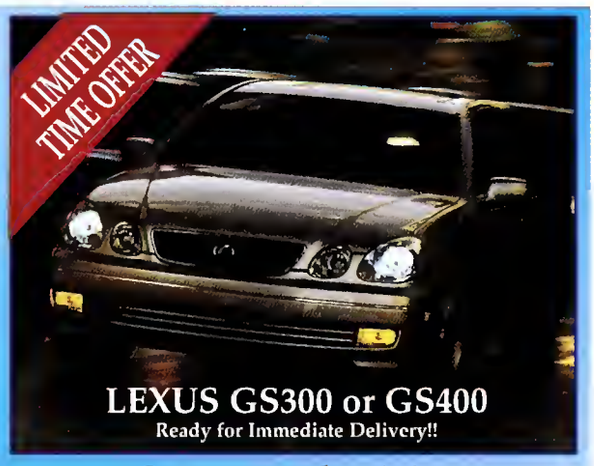

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Newsmakers

John J. Andujar, MD, Fort Worth, received the Citation of Merit Award from the Texas Society of Pathologists. The award also was renamed the John J. Andujar Citation of Merit Award in his honor.

Ophthalmologist **H. Dwight Cavanagh, MD,** was named associate dean for clinical services at The University of Texas Southwestern Medical School at Dallas.

San Antonio cardiothoracic surgeon **Leo Cuello, MD,** was appointed 1999–2000 president of the Lillehei Surgical Society.

Gastroenterologist **Walter P. Dyck, MD,** was elected associate vice president for clinical affairs and senior associate dean of Texas A&M University College of Medicine in Temple.

Austin internist **William G. Gamel, MD,** was invited to serve on a special 7-member advisory committee for the American Medical Association. The committee will report to Richard F. Corlin, MD, speaker of the AMA House of Delegates, on issues raised by the AMA's Ad Hoc Committee on Structure, Governance, and Operations.

San Antonio emergency medicine specialist **Donald Gordon, MD, PhD,** was selected chair of the newly formed American Red Cross Advisory Council on First Aid and Safety.

H. Dwight Cavanagh, MD

Leo Cuello, MD

Walter P. Dyck, MD

William G. Gamel, MD

R. Irvin Morgan, MD

Kevin Oeffinger, MD

George P. Rodgers, MD

Geoffrey Weiss, MD

Fort Worth plastic surgeon **Valentin Gracia, MD,** received the Physicians' Humanitarian Award from the Tarrant County Medical Society.

Winners of Texas Neurological Society's 1999 Young Investigator Award for neurology residents and fellows are Dallas internist **Suleiman Kojan, MD,** who earned first place for his paper, "St Louis Encephalitis: A Review of 11 Cases in a 1995 Dallas Epidemic"; and Houston pediatrician **Tim Benke, MD,** who earned second place for his paper, "Two Molecular Mechanisms for Hippocampal LTD Determined by the Recent History of Synapses: A Decrease in AMPA Receptor Conductance and in Their NSF-Dependent Surface Expression."

The 1999 staff officers of Scott & White Memorial Hospital in Temple include orthopedic surgeon **W.E. Lowry, MD,** chief; obstetrician-gynecologist **Dudley Baker, MD,** associate chief; and ophthalmologist **Paul Dieckert, MD,** secretary.

Temple pediatrician **C. David Morehead, MD,** was reelected president of the Scott & White Health Plan Board of Directors.

Please let *Texas Medicine* know about your honors and achievements. Criteria for inclusion in the Newsmakers section are TMA membership; election or appointment to an office of, or honors from, a national or state organization; or, space permitting, recognition at the local level. Items for the Newsmakers section are published at the discretion of the managing editor. Submit items for consideration, with photos if possible, to Johanna Franke, People, *Texas Medicine*, 401 W 15th St, Austin, TX 78701; fax (512) 370-1632; e-mail johanna_f@texmed.org.

R. Irvin Morgan, MD, Greenville, received the George T. Caldwell Award from the Texas Society of Pathologists.

Crockett general surgeon **Ray L. Morrison, DO,** was appointed to the Texas Department of Health's Medical Disclosures Panel.

Anesthesiologist **Joseph J. Naples, MD,** was appointed chair of the Department of Anesthesiology at The University of Texas Health Science Center at San Antonio.

Dallas family practitioner **Kevin Oeffinger, MD,** was awarded a 2-year grant from the American Academy of Family Physicians to study the long-term effects of radiation therapy on childhood cancer patients.

Falfurrias family practitioner **Richard S. Penly, MD,** was selected January 1999 Veteran of the Month by a local program sponsored by *The Falfurrias Facts,* The First National Bank in Falfurrias, and Norwest Bank Texas in Premont.

Galveston pediatrician **Ben Raimer, MD,** received the 1998 Ray E. Helfer, MD, Award for his contributions to the prevention of child abuse and neglect.

The 1999 officers of Scott & White Memorial Hospital/Scott, Sherwood, and Brindley Foundation in Temple include general surgeon **John W. Roberts, MD,** president and chief executive officer; plastic surgeon **Raleigh R. White IV, MD,** first vice president; internist **Bruce Koehler, MD,** second vice president; ophthalmologist **Paul Dieckert, MD,** secretary; and obstetrician-gynecologist **Bob Shull, MD,** treasurer.

Austin cardiovascular disease specialist **George P. Rodgers, MD,** was elected 1999 chair of the Texas Coalition on Cardiovascular Disease and Stroke, a diverse group including representatives from 59 organizations.

General surgeon **Joe Ed Smith, MD,** was named Athens' 1998 Citizen of the Year.

Wichita Falls dermatologist **Thomas E. Taylor, MD,** received the Wichita County Medical Society Distinguished Service Award.

Dallas general surgeon **David Vanderpool, MD,** received the 1999 Max Cole Leadership Award from the Dallas County Medical Society.

The 1999 Texas Society of Pathologists Young Pathologists' Section officers include **Sarah Webb, MD,** Bedford, chair; **Sherri Gillham, MD,** Midland, chair-elect; and **Michelle Hebert, MD,** Houston, secretary.

San Antonio oncologist **Geoffrey Weiss, MD,** was elected to a 2-year term as chair of the Physician Oncology Education Program (POEP) Steering Committee. Dr Weiss succeeds Houston oncologist **Charles Levenback, MD,** who served 4 years as POEP Steering Committee chair.

The 1999 Texas Society of Pathologists officers include **Thomas Wheeler, MD,** Houston, president; **Philip Valente, MD,** San Antonio, president-elect; **Alan Moore, MD,** Austin, vice president; **Oscar Abbott, MD,** San Antonio, secretary; **Kevin Homer, MD,** Fort Worth, treasurer; and **Robert McKenna, MD,** Dallas, director-at-large.

Deaths

Carl M. Austin, MD, 86; Burleson; Baylor College of Medicine-Dallas, 1941; died January 8, 1999.

Randall Dean Blackwell, MD, 44; Houston; Baylor College of Medicine, 1979; died February 3, 1999.

James Booth, MD, 75; Dallas; The University of Texas Medical Branch at Galveston, 1950; died December 4, 1998.

Marven Irvin Brook, MD, 59; Houston; Dalhousie University Faculty of Medicine-Halifax, Nova Scotia, 1963; died January 26, 1999.

Don Lee Carlisle, MD, 70; San Angelo; The University of Texas Medical Branch at Galveston, 1958; died January 16, 1999.

John Hill Cayce, MD, 74; Fort Worth; The University of Texas Medical Branch at Galveston, 1947; died January 6, 1999.

Reinhardt David Dwyer, MD, 81; Houston; University of Wisconsin Medical School, 1944; died January 13, 1999.

Charles Gilbert Freundlich, MD, 83; Houston; The University of Texas Medical Branch at Galveston, 1940; died December 18, 1998.

Bao-Shan Jing, MD, 85; Bellaire; National Medical College of Shanghai-China, 1938; died January 12, 1999.

Ronald Wayne Kasper, MD, 54; Round Rock; The University of Southwestern Medical School at Dallas, 1971; died January 16, 1999.

Richard L. Kornreich, MD, 55; Tomball; Universidad Autonoma de Guadalajara-Mexico, 1975; died January 28, 1999.

Tulsi Indru Malkani, MD, 54; Austin; Topiwalla National Medical College-Bombay, India, 1968; died January 28, 1999.

Al King Marshall, MD, 71; Fort Worth; The University of Texas Medical Branch at Galveston, 1953; died February 4, 1999.

Lorenzo Froilan Martin, MD, 88; Corpus Christi; Habana University School of Medicine-Habana, Cuba, 1938; died December 23, 1998.

James Merida McCleery, MD, 74; Pasadena; University of Oklahoma College of Medicine, 1952; died January 3, 1999.

John Francis McCluskey, Jr, MD, 62; Silsbee; University of Pennsylvania School of Medicine, 1961; died January 27, 1999.

Arch James McNeill, MD, 89; Dallas; Baylor College of Medicine-Dallas, 1936; died January 22, 1999.

John Paul Puckett, MD, 73; Alpine; The University of Tennessee-Memphis College of Medicine, 1949; died January 19, 1999.

John Valton Sessums, Jr, MD, 70; Bellville; The University of Texas Medical Branch at Galveston, 1954; died February 11, 1999.

David Heaton Smith, MD, 93; Victoria; The University of Texas Medical Branch at Galveston, 1931; died February 1, 1999.

Albert Ada Tisdale, MD, 92; Austin; Louisiana State University School of Medicine-New Orleans, 1935; died February 16, 1999.

Ephraim Lionel Wagner, MD, 88; Houston; Tulane University School of Medicine, 1941; died January 30, 1999.

Patrick Joseph Wagner, MD, 63; Shiner; The University of Texas Medical Branch at Galveston, 1961; died January 20, 1999.

Alvin Lloyd Woldman, MD, 73; San Antonio; Tulane University School of Medicine, 1951; died February 21, 1999.

David Vance Wray, MD, 52; Houston; Baylor College of Medicine, 1972; died February 21, 1999.

Glenn Roy Zipp, MD, 62; New Braunfels; The University of Texas Medical Branch at Galveston, 1961; died January 20, 1999.

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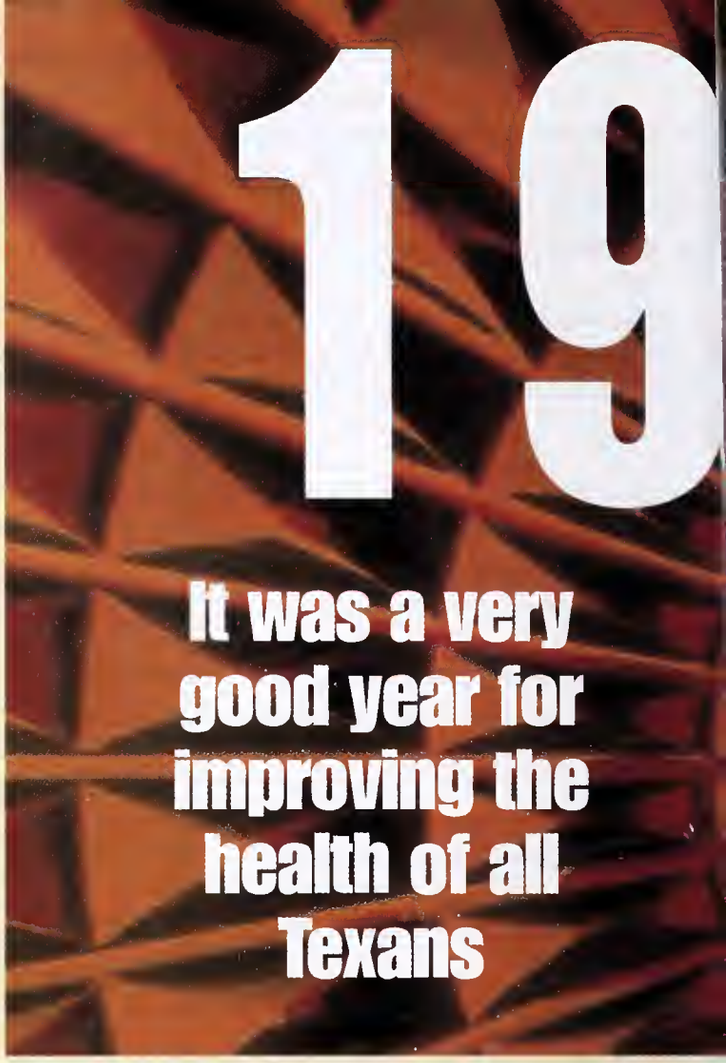

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Texas Medicine Rounds

By Johanna Franke

Naming names

TDH implements HIV/STD reporting changes

At the end of 1998, the Texas Board of Health approved reporting changes for certain sexually transmitted diseases (STDs). The Texas Department of Health (TDH) implemented these changes on January 1, 1999. Reporting requirements were changed for HIV, AIDS, chancroid, *Chlamydia trachomatis,* gonorrhea, and syphilis.

Also, definitions of HIV, AIDS, and STDs were amended to be consistent with those used by the Centers for Disease Control and Prevention (CDC).

Name-based HIV reporting is the most significant change. To solicit input from health professionals, patients with HIV/AIDS, and the community at large, TDH conducted extensive community meetings throughout the past year. Detailed descriptions of the information-gathering and decision-making processes involved in these changes are available on the Internet at www.tdh.state.tx.us/hivstd/input.htm.

Beginning January 1, laboratories and health care providers started reporting confirmed cases of HIV infection by name to the local surveillance authorities. To report cases, providers can call (800) 705-8868, which will automatically connect callers to local offices.

Need for reporting HIV by name

AIDS has been reportable by name in Texas since 1983. Recent advances in the treatment and prevention of HIV infection have resulted in a decrease in AIDS mortality and an increase in the length of time from HIV infection until the development of AIDS. Thus, reliable reporting of AIDS no longer provides adequate information for understanding the epidemiology of HIV in Texas. National, state, and local advocacy groups agree that it is critical to have better monitoring of HIV infection. Accurate data are essential to ensure that resources for HIV prevention and services are directed to the communities and groups bearing the greatest burden of HIV disease. It also allows resource allocations to be more sensitive to shifts in the HIV epidemic.

Since 1994, Texas has used an HIV reporting system based on assigning each case a unique number. However, HIV reporting systems that use names produce more reliable information about the epidemic than do non-named

systems. States that have HIV reporting by name report that their systems miss only 3% to 26% of the diagnosed HIV cases in those states. By comparison, the non-named system used to report HIV in Texas missed about 74% of the cases diagnosed in 1995 and 1996. This poor level of reporting hinders the ability to understand the epidemic's changing demographics and the ability to monitor it.

In addition to incomplete reporting, a non-named system doesn't allow the health department to follow up with providers and their patients to ensure that patients are offered appropriate referral for available services and voluntary partner notification. The follow-up by trained public health employees means that all individuals with HIV whose cases have been confirmed receive the following:

- Notification that they are infected with HIV.
- Appropriate referral to health and social services.
- Assistance in telling their sex and/or drug use partners of their possible exposure to HIV.

Procedure

The following information is required to complete a morbidity report for each confirmed HIV infection:

- The name, address, birth date, sex, and race/ethnicity of the infected person.
- The test type, test date, and test result.
- The name and address of the provider who makes the HIV diagnosis.

The local surveillance authority will follow up with local providers to complete an HIV infection case-reporting form. The local authority also will work with providers to ensure that the infected individual:

- Knows his or her test result,
- Has been referred to medical and social services, and
- Has been offered assistance in notifying his or her sex and needle-sharing partners that they may have been exposed to HIV.

The local surveillance authority will send case reports to TDH in Austin. TDH will remove identifying information and send aggregate reporting data to CDC.

Retroactive reporting of HIV by name is not required. TDH will accept case reports having test dates that fall on or after January 1, 1999. Persons whose last positive HIV test falls before that date will not be reported to the surveillance system by name until they develop AIDS.

Anonymous HIV testing

People who do not want to have their real names placed on their HIV tests can choose to be tested anonymously. TDH is committed to making anonymous HIV testing accessible to people in all areas of Texas. Under Texas law, all public health clinics must offer anonymous testing or give referrals to sites that do.

Additionally, all HIV testing sites that receive funds from TDH must offer anonymous HIV testing on site. The names of people who test positive with anonymous tests will not be reported. Anyone can call (800) 299-AIDS to find out the closest location where anonymous HIV testing is available.

Security measures

Surveillance information is not public information. By law, all surveillance information, including HIV reporting information, is confidential and privileged. This means that no one can find out a person's HIV status by filing an open records request or a Freedom of Information Act request. The circumstances under which surveillance information containing a name may be released are very limited. These include protecting the health of a spouse, health care workers, first responders, emergency personnel, peace officers, firefighters, and victims of sexual assault. Surveillance workers who inappropriately release or disclose surveillance information face various legal sanctions; intentional or criminally negligent breaches of confidentiality are Class A misdemeanors.

Surveillance workers cannot be subpoenaed or deposed to release surveillance information about an individual. They cannot be questioned in a civil, criminal, special, or other proceeding about the existence or contents of surveillance records of a person examined or treated for a reportable disease without that person's consent. Surveillance workers do not give law enforcement agencies, immigration agencies, insurance companies, employers, or families access to the databases that contain surveillance information. Local, regional, and state surveillance workers have successfully guarded the names of more than 46,000 AIDS patients for 15 years without a known breach of confidentiality in the surveillance system.

State and local surveillance sites use the following security measures to ensure confidentiality:

- Staff members are required to sign confidentiality agreements, and are subject to criminal and civil penalties and loss of employment if they breach confidentiality. They receive training in how to conduct case investigations and handle information while maintaining data security and confidentiality.
- Physical barriers separate the public from the areas where the information is kept. The computers that hold the data are not accessible to the public or other public health workers outside the surveillance unit. These computers are standalone systems and cannot be accessed through modems or the Internet. A limited number of surveillance workers at each site can access the databases.
- The surveillance system is secured electronically through passwords, encryption, and security card access.
- TDH conducts regular security audits of local surveillance sites — some of which are unannounced visits — to ensure that strict security procedures are observed.

For more information, contact Sharilyn Stanley, MD, chief of the TDH Bureau of HIV/STD Prevention, at (512) 490-2505. ★

Source: Texas Department of Health

TMA vice speaker gigs 'em on A&M board

Susan Rudd Wynn, MD, vice speaker of the Texas Medical Association House of Delegates, has been appointed to the Texas A&M University System Board of Regents by Gov George W. Bush. Dr Wynn, a Fort Worth allergy and immunology specialist, was among three new A&M regents the governor appointed in mid-February.

"I'm really looking forward to being able to have a leadership role to foster the continued success and growth of the College of Medicine as well as all of the health science-related activities," said Dr Wynn, who added that her appointment was "not something I sought at all. They called me up out of the blue." She said it never occurred to her when she first enrolled as a student in 1974 that she would one day serve on the Board of Regents. Dr Wynn received her medical degree from A&M in 1981.

With the medical school's designation as a health science center and the addition of the Baylor College of Dentistry to the system, A&M "has become very active in the health care arena," she said.

Governor Bush said Dr Wynn and the other new regents "are excellent appointees with diverse experience who bring valuable insight and strong leadership to the board."

Dr Wynn says she has no plans to curtail any of her TMA activities. In addition to being vice speaker of the House of Delegates, she has served as chair of the Young Physician Section, the Council on Communication, and the Healthy Patient 2000 Task Force. She has been a member of the Texas Delegation to the American Medical Association since 1991 and was the 1996–1997 president of the Tarrant County Medical Society.

Other professional memberships include American Academy of Allergy, Asthma and Immunology; American Academy of Pediatrics; and the Texas Allergy and Immunology Society.

Finally, Dr Wynn says that despite her appointment as an A&M regent, she will fulfill her obligation to carry her TexMed '99 papers in a burnt orange University of Texas notebook as a result of losing a bet on last year's Texas-Texas A&M football game to House of Delegates Speaker Tom Hancher, MD. "A good Ag keeps her commitments," she said. ★

Susan Rudd Wynn, MD

Baylor creates gene function lab

Baylor College of Medicine researchers hope a new laboratory to study gene functions in mice and humans will help them develop new disease treatments.

Investigators at Baylor's Comparative Gene Function Laboratory will study mouse chromosomes 4 and 11 because they are very similar to chromosomes 1 and 17 in humans and are associated with various tumors. Through their research, scientists hope to identify the genetic mutations that could be causing the tumors.

The new laboratory was funded by a $1.5 million gift from the Robert J. Kleberg, Jr, and Helen C. Kleberg Foundation based in San Antonio. ★

Medicaid enrollees: do it right

Medicaid providers have until September to reenroll with the National Heritage Insurance Company (NHIC) but are strongly encouraged by NHIC to return accurately completed packets quickly.

As of February 1, fewer than 2% of the packets had been returned, and most were incomplete or inaccurate. According to NHIC, the most common reasons packets are returned to physicians are the lack of an original signature, an inaccurate notary public stamp, and failure to append necessary attachments. Because the form is a legal document, it must be originally signed and notarized; photocopies are unacceptable.

Even those physicians who already have a Medicaid number must reenroll. If they don't, they will be dropped from the program on September 1. Claims submitted after this deadline also will be denied.

NHIC urges physicians and other health care providers to return their packets by June 1 to ensure timely processing. Physicians who currently have multiple provider numbers received duplicate packets, though only one must be returned. The exception is for some group-based physicians who practice at multiple locations.

This initiative is driven by Senate Bill 30, which the 1997 Texas Legislature enacted. It obliges providers to sign a new agreement stipulating that they will comply with the state's Medicaid program integrity efforts.

For information on the reenrollment process or if you did not receive a form, contact NHIC customer relations at (800) 925-9126.

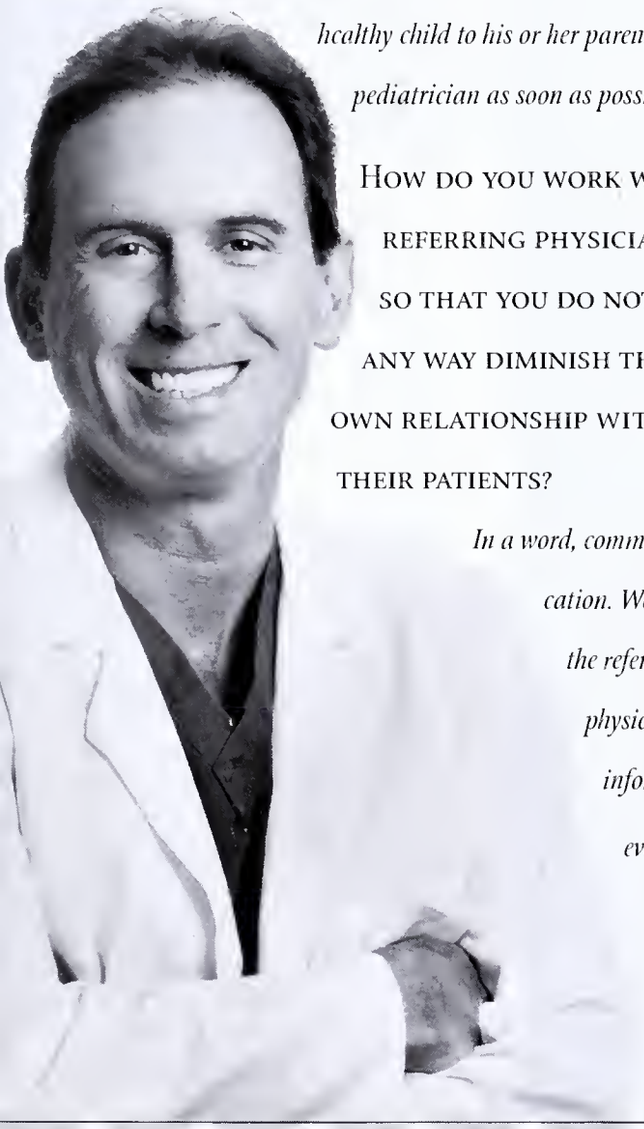
Also, frequently asked reenrollment questions along with their answers are posted on TMA's Web site at www.texmed.org under "Medicare/ Medicaid" in the "Business of Medicine" section. ★

The Expertise Referring Physicians Have Come To Count On: Cook Children's Talks With Dr. Lawrence Fox.

DR. LAWRENCE FOX — MEDICAL DIRECTOR OF CARDIOVASCULAR SURGERY

DR. FOX, YOU ARE ONE OF ONLY A FEW PEDIATRIC CARDIOVASCULAR SURGEONS IN THE U.S. WHO PERFORM CORRECTIVE SURGERY FOR HYPOPLASTIC LEFT HEART SYNDROME. AS YOU WORK WITH REFERRING PHYSICIANS, WHAT IS IT THAT PROMPTS THEM TO CONTINUE TO REFER PATIENTS TO YOU FOR THIS AND OTHER PEDIATRIC HEART PROBLEMS?

The child's primary care physician knows we're committed to delivering the highest quality care, and that we have the expertise and technology to do things other hospitals can't. Our goal is to return a healthy child to his or her parents and pediatrician as soon as possible.



HOW DO YOU WORK WITH REFERRING PHYSICIANS SO THAT YOU DO NOT IN ANY WAY DIMINISH THEIR OWN RELATIONSHIP WITH THEIR PATIENTS?

In a word, communication. We keep the referring physician informed every step of the way. After the operation is done, the primary care doctor gets a call and a letter, and the same occurs on the day of the patient's discharge. Also, our nurses make sure to keep the referring physician informed about any changes in the patient's condition.

WHAT DO REFERRING PHYSICIANS THINK ARE THE KEYS TO EXCELLENT PEDIATRIC SPECIALTY CARE?

They want to see us care for the patient's problem with a good result and return the patient to them promptly. Referring physicians also know that we do a lot of surgeries at Cook Children's, and it's like anything else – the more you do, the better the outcomes. Another thing they appreciate is the fact we have a cardiac support group that helps reduce the stress of families and everyone involved.

CAN YOU RELATE AN INTERESTING CASE WHICH EXEMPLIFIES THE TRUST OF REFERRING PHYSICIANS IN YOUR SPECIALTY CARE HERE AT COOK CHILDREN'S?

Yes. A baby was born with a condition known as transposition of the great arteries, which means the position of the heart's major arteries needs to be "switched." If uncorrected, most babies will die in the first few weeks of life. The referring physician knew we performed many of these complex operations with a very high level of success, and was therefore calling to have our team care for his patient.

Cook Children's Medical Center is located in Fort Worth, Texas. For more information on Dr. Fox and his partner in Cardiovascular Surgery, Jeffrey Heinle, call 1-800-COOK517.

CookChildren's
Medical Center

SUMMARIES OF RECENT HEALTH CARE HEADLINES

In Case You Missed It

By Melissa McEver

New evidence that the eating disorder bulimia is caused at least partly by a chemical malfunction in the brain was found by researchers at the UNIVERSITY OF OXFORD. Women who had recovered from bulimia were more affected psychologically by deprivation of the amino acid tryptophan than other women. When given foods without tryptophan, the recovered bulimics reported greater mood swings, worries about body image, and fear of losing control of eating than the other women in the study.
(*Archives of General Psychiatry*, 2/99)

The diet of people from Mediterranean countries, already found to reduce cancer risk, can promote health in more ways than one. A recent French project known as the Lyon Diet Heart Study reported that a Mediterranean-style diet, which is rich in fruits, vegetables, fish, and beans, might protect people from having a second heart attack. DR MICHEL DE LORGERIL and colleagues studied more than 400 previous heart attack sufferers for nearly 4 years and found that the people who ate traditionally Mediterranean fare are 50% to 70% less likely to suffer repeat heart attacks.
(*Circulation*, 2/16/99)

A recent study reveals that prostate cancer may progress more rapidly in African American men than in Anglo men, and their cancer may be more likely to recur. Scientists at WAYNE STATE UNIVERSITY in Detroit examined tumor specimens from 333 African American men and 426 white men who had undergone surgery for prostate cancer. They found that the African American patients between the ages of 50 and 69 tended to have more advanced cancer than their Anglo counterparts at the time of surgery and that their cancer was more likely to have spread beyond the prostate.
(*Cancer*, 1/15/99)

Claims that the controversial fat substitute olestra may cause serious gastrointestinal problems might be unfounded, a new report has concluded. Researchers at the UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL studied 3,100 adults and children who consumed olestra-containing products, such as corn or potato chips, during a 6-week period. The participants reported slightly more nausea and 1 more day of more frequent bowel movements than those who consumed regular chips. The researchers concluded that under ordinary snacking conditions, olestra-containing foods should cause no more problems than regular, fatty snacks.
(*Annals of Internal Medicine*, 2/16/99)

Survey shows no progress

The first survey of the Texas Medical Association Continuous Survey Project's second year was designed to monitor the implementation of the 1997 Texas laws concerning patient protection and Medicaid. A 1997 survey measured the baseline data, so the results of the latest survey show the impact of the new laws.

In January, surveyed physicians reported no significant declines in the frequency of problems with many managed care practices that are prohibited by new Texas laws compared with 1997. They also reported an increase in problems with unqualified reviewers and in complaints that were not resolved within 30 days. The survey says physicians still are having difficulties with continuity of care, out-of-network referrals, "hold harmless" contract clauses, slow processing of medical necessity appeals, the complaint process, financial incentives, and patient care quality. Surveyed physicians reported that the top three causes of adverse impact on patient care quality are delays in specialist referrals, restricted formularies, and limited panels of specialists.

Though survey results show little change in the past year in the number of Medicaid patients accepted, striking differences arise when responses are examined by specialty. New Medicaid patient acceptance by pediatricians declined from 62% in 1997 to 42% in 1998, while new Medicaid patient acceptance by psychiatrists dropped from 36% to 22% during the same period. Surveyed physicians report that despite new laws requiring timely payments, only 33% of Medicaid claims were paid within 45 days in 1998, which is a dramatic decline from the 60% that were paid within that time frame in 1997. Medicaid access may worsen, as 26% of surveyed physicians report they are considering policy changes that would impose new limits on new Medicaid patients and 16% say they would not accept any new Medicaid patients. When asked about measures that might encourage them to increase their Medicaid participation, 64% of surveyed physicians strongly favored a Medicaid fee increase. ★

COUNTRY MANOR SHAKE

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TexMed'99

New TMA/TMAA leaders to be installed next month

Alan C. Baum, MD, Houston, and Pam Hendricks, Temple, will assume the presidencies of the Texas Medical Association and the TMA Alliance (TMAA), respectively, on Friday, May 7, during TexMed '99: Educational Showcase & Expo.

An ophthalmologist and partner at the Texas Eye Institute in Houston, Dr Baum chairs the TMA Committee on Liaison with Medical Schools and is a past chair for both the TMA Board of Trustees and TEXPAC, TMA's political action committee. Dr Baum is an assistant clinical instructor at The University of Texas-Houston Medical School, and has served as president of the Texas Ophthalmological Association (TOA) and the Southwest Branch of the Harris County Medical Society (HCMS). He has chaired the HCMS Medical Legislative Board and Council of Specialty Societies and has earned distinguished ophthalmologist awards from TOA and the Houston Ophthalmological Society. Dr Baum also has served as chief of staff at Memorial Southeast Hospital in Houston and chair of the ophthalmology sections of both the Memorial Southwest and Memorial Southeast hospitals.

Alan C. Baum, MD

A native of Fort Scott, Kan, Dr Baum earned his bachelor's degree at The University of Texas at Austin and his medical degree at The University of Texas Medical Branch at Galveston. He was a captain in the 147th Fighter Squadron of the Texas Air National Guard from 1969 to 1975. Dr Baum is a member of the American Academy of Ophthalmology, Houston Ophthalmological Society, and American Medical Association.

Ms Hendricks has been a volunteer for numerous organizations including Habitat for Humanity, Central Texas Partners in Health, Temple Healthy Communities Initiative, Temple Sister Cities Corporation, and the Temple Independent School District. She has donated much time to the city of Temple by serving on its Main Street Advisory Board, Board of Building Appeals, Citizens' Task Force on Recycling, and Socioeconomic Task Force. Ms Hendricks also has participated in community programs such as Leadership Temple and Leadership Texas.

While completing her bachelor's degree in medical technology at the University of Iowa, Ms Hendricks met her husband, general surgeon John Hendricks, MD. They have lived in Temple 17 years and have three children.

Pam Hendricks

Dr Baum and Ms Hendricks will be honored during a joint installation luncheon on May 7, from noon to 1:30 pm, in the Wyndham Anatole Hotel's Chantilly Ballroom West. Tickets for the luncheon, which is partially underwritten by the Texas Medical Association Insurance Trust and Teachers Insurance and Annuity Association-College Retirement Equity Fund, are $15 each and must be purchased in advance. For more information, call Shari Dudney at (800) 880-1300, ext 1454, or (512) 370-1454; or e-mail shari_d@texmed.org. ★

Focus on the future with TexMed '99 speakers

Look what's in store for you at TexMed's opening general session, which is brought to you through an exclusive partnership with the Texas Medical Liability Trust: Helen Hobbs, MD, exploring the controversial topic of genetics; Ellen Wright Clayton, MD, JD, delving into the ethical issues surrounding the advancements in genetics; and Abraham Verghese, MD, telling his poignant story of a colleague's addiction to cocaine. And a second general session has been added this year, with Wayne Sotile, PhD, and his wife, Mary Sotile, MA, discussing successful physician marriages and relationships with colleagues. Attend the opening general session on Thursday, May 6, from 2 to 5 pm, and the second general session on Saturday, May 8, from 8 to 9 am at the Wyndham Anatole Hotel's Stemmons Auditorium.

To kick off the opening general session, noted geneticist Dr Hobbs will investigate the promise genetics holds for revolutionizing medicine in the coming years in her presentation, "How Genetics Will Influence the Practice of Medicine in the 21st Century." A fascinating speaker on a hot topic, Dr Hobbs will share her dedication to the Center for Human Genetics at The University of Texas Southwestern Medical School at Dallas, an important new facility that brings genetic discoveries to clinical medicine. A professor of internal medicine and molecular genetics at UT Southwestern, Dr Hobbs is interim director of the center and a board-certified internist and endocrinologist who rotates on the teaching wards at Parkland Hospital and sees patients with genetic disorders.

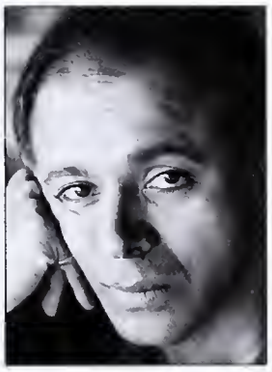
Helen Hobbs, MD

Need ethics continuing medical education credit? Then be sure to attend the thought-provoking presentation, "Addressing the Challenges of Privacy and Confidentiality in the 21st Century." Dr

Clayton, who is active in debates about access to genetic information and research, will discuss the ethical issues behind the disclosure of genetic data to family members. She is an associate professor of pediatrics at Vanderbilt University School of Medicine in Nashville and an associate professor of law at Vanderbilt University School of Law.

Ellen Wright Clayton, MD, JD

Dr Verghese concludes the opening general session on Thursday with his keynote presentation "Healing the Healer: The Balance Between Patient Care and Care of One's Self." A best-selling author, Dr Verghese will discuss suicide and drug abuse among physicians using experiences from his latest book *The Tennis Partner: A Doctor's Story of Friendship and Loss.* Dr Verghese is chief of infectious diseases at Texas Tech University Health Sciences Center in El Paso.



Abraham Verghese, MD

In Atrium I following the opening general session, a special "Meet the Speakers" reception and book signing with Dr Verghese will give you a chance to visit with the speakers. This wine and cheese reception is sponsored by the Texas Medical Liability Trust in celebration of its 20th anniversary. Also, a special sculpture presentation will be made in memory of the late San Antonio psychiatrist Victor J. Weiss, Jr, MD, at the conclusion of the opening general session.

On May 8, the Sotiles will take on stress management for contemporary couples and families at the second general session in Wyndham Anatole Hotel's Stemmons Auditorium. The husband-and-wife team's presentation, "Where Are the Heroes? Keeping the Flame Alive at Home and Work," will address medical marriages and relationships with colleagues of both genders and all ages. The Sotiles will be available following their program to visit and sign copies of their books on medical marriages.

Mary Sotile, MA, and Wayne Sotile, PhD

For more information, call Paula Rigling at (800) 880-1300, ext 1450, or (512) 370-1450; or e-mail paula_r@texmed.org. Or consult the TexMed '99 Web site at virtual.texmed.org. ★

House of Delegates meets in Dallas next month

The House of Delegates, Texas Medical Association's policy-making body, will convene in Dallas Thursday and Friday, May 6–7, as part of TexMed '99 to address numerous issues members have raised.

The opening session, which includes addresses from the TMA and TMA Alliance presidents as well as the presentation of TMA's Distinguished Service Award to Sam A. Nixon, MD, begins at 8 am in the Wyndham Anatole Hotel's Stemmons Auditorium on May 6. Reference committees will hold hearings immediately after the House recesses to consider resolutions from county medical societies and reports from TMA boards, councils, committees, and sections.

On May 7, the House will hold elections and vote on reference committee recommendations beginning at 9 am in Wyndham Anatole Hotel's Khmer Pavilion. All TMA members are welcome to attend Thursday's and Friday's sessions, which also include legislative updates. For more information, call Pam Hale at (800) 880-1300, ext 1304, or (512) 370-1304; or e-mail pam_h@texmed.org. ★

BEFORE YOU SIGN

Contract TIPS

Things you need to know

Austin attorney mediator Andre Hampton, JD, and the TMA Office of the General Counsel suggest an ideal managed care contract should:

- **Provide for payment for emergency care services notwithstanding any preauthorization requirements, and define emergency care in accordance with the understanding of a prudent layperson.**
- **Specify the amount and type of insurance covering the managed care organization's activities under the contract and provide that you will be covered as an additional insured.**
- **Not require you to obtain more insurance coverage or different types of insurance than your current insurance.**
- **Provide a fee schedule that can be translated into real dollars per hour or dollars per procedure.**
- **Not require that you indemnify and hold harmless any other party or agree to be "solely responsible" for any harm to covered patients.**

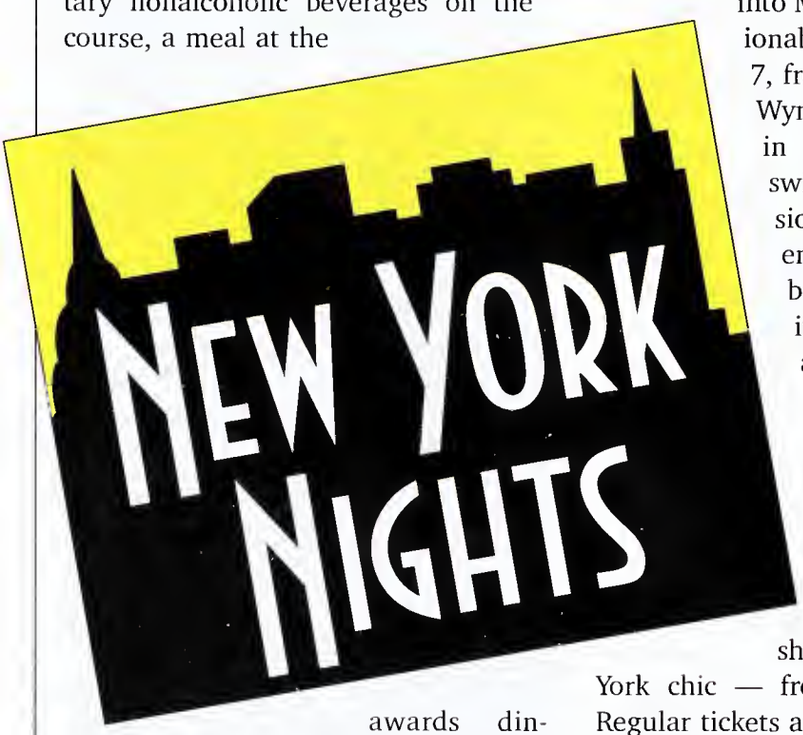
Source: TMA Physician Services. For more information about TMA Physician Services or to request a copy of the catalog, call (800) 523-8776, or (512) 370-1418; or e-mail physician_services@texmed.org.

TexMed'99

Get into the swing of things at TMAF tournament, benefit

Swing dance or swing golf clubs — either way, you're helping the Texas Medical Association Foundation (TMAF) raise funds to improve the health of all Texans during TexMed '99.

On May 5, work on your golf swing at the C. Lincoln Williston Golf Tournament benefiting TMAF at Riverchase Golf Course in Coppell, just outside of Dallas. The tournament features the shortgame format again this year. The entry fee is $125, which gives you 18 holes of golf with a cart, an official tournament golf shirt, the shortgame clinic, on-course contests, complimentary nonalcoholic beverages on the course, a meal at the awards dinner, team photos for each player, and use of the practice range and putting green. The registration deadline is April 14. Additional information will be provided in the registration acknowledgment letter.



The tournament is named after the late C. Lincoln Williston, who served as TMA's executive director from 1954 to 1987. During his 33-year tenure, Mr Williston transformed TMA into one of the nation's top state medical societies where it remains today. Under his leadership, TMA membership tripled, the association's group insurance program was launched, and the library grew to more than five times its original size. In February, Mr Williston lost his 11-year battle with leukemia, but throughout his illness, he remained a loyal supporter of TMA and TMAF. This tournament both honors and celebrates Mr Williston, his commitment to TMA and TMAF, and his avid love for golf.

Once you take off your golf shoes, slip on your dancing shoes and step into Manhattan's most fashionable nightclub on May 7, from 6 to 11 pm, at the Wyndham Anatole Hotel in Dallas. Learn some swing steps from professional dance instructors, enjoy a delicious dinner, bid on your favorite items in TMAF's silent auction, and experience the art-deco ambience of the stylish New York atmosphere while you listen to tunes from "T-Byrd" Gordon and his 16-piece show band. Dress is New York chic — from casual to festive. Regular tickets are $100, but for $125, you'll be recognized as a New York City Sponsor in the event program and the TMAF newsletter.

For more information on both TMAF events, call Heather Summers at (800) 880-1300, ext 1466, or (512) 370-1466; or e-mail heather_s@texmed.org. ★

YPS prepares for future at TexMed '99

As the new millennium approaches, young physicians need to do more than react to changes in the health care environment — they need to shape them. With help from Paul B. Handel, MD, vice chair of Texas Medical Association's Council on Socioeconomics, TMA's Young Physician Section (TMA-YPS) will be ready to take on "Medicine's Millennium Problems and Promises."

Dr Handel will discuss managed care developments — from the Aetna lawsuit to insurance reimbursement issues — at the TMA-YPS meeting on Saturday, May 8, at Dallas' Wyndham Anatole Hotel. Held in conjunction with TexMed '99, Dr Handel's PowerPoint presentation will show how managed care is impacting the practice of medicine.

"I also will discuss what the Texas Medical Association, the county medical societies, and the American Medical Association have been doing in concert to restore the sanctity of the patient-physician relationship as well as the true essence of the profession of medicine," he said.

Dr Handel sums up the reason why young physicians need to be involved actively in the future of medicine with a quote from Robert Wood Johnson: "They need to be concerned about the future because they're going to spend the rest of their lives there."

A urologist from Houston, Dr Handel has served on TMA's Patient-Physician Advocacy Committee and the association's Special Committee on Health System Reform. He is past president of the Harris County Medical Society and a former chair of the society's boards on socioeconomics and medical legislation. Dr Handel is a member of the boards of directors for organizations such as Physicians, Inc, the Gulf Coast Regional Blood Center, the Houston Healthcare Purchasing Organization, and the Houston International Theater School.

For more information on the YPS meeting, call Pamela Allen at (800) 880-1300, ext 1402, or (512) 370-1402; or e-mail pamela_a@texmed.org. ★

WEB SITES OF INTEREST TO TEXAS PHYSICIANS BY JOHANNA FRANKE

MedBytes

April's "MedBytes" offers sites on end-of-life care and pain management.

The EPEC Project

The Web site for the American Medical Association's Education for Physicians on End-of-life Care (EPEC) Project houses EPEC background information, a hospice and palliative care questionnaire, and a list of individuals accepted to attend EPEC regional conferences. The site at www.ama-assn.org/ethic/epec also includes a list of EPEC speakers and a resource guide.

Choice In Dying

The nonprofit organization that invented living wills in 1967, Choice In Dying provides advance directives, counsels patients and families, trains professionals, advocates for improved laws, and offers a range of publications and services. The organization's Web site at www.choices.org includes background information on end-of-life issues, legal developments, the Choice In Dying newsletter, and state-specific documents.

American Health Decisions

Another nonprofit organization, American Health Decisions (AHD), is a national coalition of citizens' groups concerned about ethical issues in health care. AHD has posted the executive summary of its October 1997 research report on Americans' values, concerns, hopes, and fears regarding end-of-life care at www.ahd.org/library/statements/quest.html.

Pain management organizations

The American Academy of Pain Management site at www.aapainmanage.org includes "Find a Pain Management Program" and "Find a Pain Management Professional" directories as well as a listing of books related to pain management, pain program accreditation information, and continuing medical education opportunities. The American Pain Society site at www.ampainsoc.org offers news and opportunities for pain management physicians, a pain treatment facilities directory, a calendar of events, and resources for pain patients and pain professionals.

PainNet

Though Pain Net, Inc, was developed by physicians, educators, and business professionals to provide educational and support services to physicians and other health care professionals throughout the nation, its Web site at www.painnet.com is probably better for consumers than providers. The "Doctors Only" section includes a "Physician Pain Medicine Practice Opportunities" page and links to other pain resources.

TMA's online advocacy resource center

TMA's Web site at www.texmed.org includes a new listing of advocacy services the association provides for physicians in the "Business of Medicine" section. Surf to the TMA Advocacy Resource Center to find information on managed care contracting, Medicaid, Medicare, medical insurance, Workers' Compensation, rural health, regulations, legislation, recent court decisions, and TMA's payment advocacy efforts.

MedBytes is a quick look at new, or newly discovered, Web sites of interest to Texas physicians. The column also highlights features of the TMA Web site at www.texmed.org. If you know of some cool medical sites or have questions about how to use the TMA Web site, e-mail johanna_f@texmed.org. Publication of information about Web sites in this column is not to be considered an endorsement or approval by the Texas Medical Association of the sites or sponsors, or of any products or services involved.

CONNECT TO TMA

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Call this 24-hour hotline to report information concerning physicians who may be abusing alcohol or other drugs, or who may be chemically addicted, psychiatrically impaired, or have other problems. All calls are confidential.

Insurance (800) 880-8181
The Texas Medical Association Insurance Trust offers life, health, disability, office overhead, personal accident, and other insurance plans and products to TMA members, their families, and office staffs.

Loans (800) 880-2828
TMA offers qualified medical students and residents low-interest loans. Call for general requirements and application procedures.

TEXPAC (800) 880-1300, ext 1362
The TMA Political Action Committee speaks on behalf of physicians through grassroots involvement, personal relationships with elected officials, and political campaign participation and contributions.

TMA Physician Services (800) 523-8776
TMA Physician Services delivers physicians and physician organizations an array of products and services to help them succeed in the changing medical marketplace.

Use the following prefixes plus @texmed.org to e-mail for TMA resources.

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Dr and Mrs James F. Herd

TMA Foundation thanks major donors

The Texas Medical Association Foundation (TMAF) can now help more patients across the state on behalf of Texas physicians, thanks to a recent major gift from Dr and Mrs James F. Herd of Fort Worth.

For Dr Herd, an obstetrician and gynecologist, and his wife, Beverlee, a former TMA Alliance president and member of the TMAF Board, taking care of people via the medical profession has been a way of life. Dr Herd, whose father was a physician, has delivered thousands of Texans during the last 30 years, and Mrs Herd spent several years as a nurse and nurse instructor. Their son has followed in his father's and grandfather's footsteps as well.

"Physicians have been improving the health of Texans for hundreds of years, one patient at a time," Ms Herd said. TMAF "is doing what individual physicians cannot do — making a collective difference in the health of all Texans. It is a pleasure for us to share with all Texans the great legacy that Texas physicians have to give — the TMAF and the programs it funds."

If you are interested in discussing a major gift to TMAF, call Lisa Stark Walsh at (800) 880-1300, ext 1666, or (512) 370-1666; or e-mail lisa_w@texmed.org. ★

Scholarship program benefits minorities

If you have received a Texas Medical Association Minority Scholarship Program mailing, don't toss it aside. Your help can make a big difference in future physicians' lives by giving them the opportunity to train among the nation's finest at a Texas medical school.

A year ago, the House of Delegates approved the creation of a scholarship program, supported solely by member donations, for qualified, underrepresented minority medical students. This decision came after 2 years of watching the negative effects of the *Hopwood* ruling on minority enrollments and, as reported by the American Association of Medical Colleges, an overall downturn in the number of minorities choosing to pursue a career in medicine.

Minorities will represent 52% of Texas' population by 2020, and meeting their health care needs may be challenging. Many are underinsured or uninsured. Anecdotal information suggests that minority individuals may delay seeking health care in the absence of minority physicians, which would result in more serious illnesses and less preventive care.

At the 1998 House of Delegates Interim Session, TMA President John P. Howe III, MD, San Antonio, unveiled the TMA Minority Scholarship Program to help send the message across the state and nation that Texas physicians not only care about diversity in medicine, but also are willing to fund efforts toward its increase.

The program is designed to increase the state's minority applicant pool, make Texas medical schools more competitive with out-of-state schools, and improve medical access for Texans in underserved areas by encouraging scholarship recipients to practice in areas of the state where they are needed most. The first scholarship will be awarded next month.

For more information, call Marcia Collins at (800) 880-1300, ext 1451, or (512) 370-1451; or e-mail marcia_c@texmed.org. ★

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Public health school approved at UNT

The Texas Higher Education Coordinating Board has approved a new public health school at the University of North Texas (UNT) Health Science Center in Fort Worth. The board recommended that the legislature fund the school for the next 5 years for $13.2 million.

The UNT School of Public Health will offer a master's degree in public health, a doctorate in public health, and a doctorate of philosophy degree in epidemiology. ★

Newspaper misinterprets Baylor polio findings

A Baylor College of Medicine scientist says the *London Sunday Telegraph* misinterpreted her study about a possible link between an early polio vaccine and cancer, according to a February 18 Associated Press report.

The *London Sunday Telegraph* based its story on a study published in January in the *Journal of the National Cancer Institute.* In this study, Janet S. Butel, PhD, head of the Division of Molecular Virology at Baylor, reviewed her research and that of others on the spread and disease potential of a monkey virus called simian virus 40 (SV40). The virus was found to have contaminated a polio vaccine used from 1955 through 1962. Dr Butel's research found that the SV40 virus causes cancers in laboratory animals and is present in a variety of human cancer tumors. In her study, Dr Butel said the association of SV40 with human cancers is strong enough to warrant serious concern but that further studies are needed to prove whether the virus actually causes cancer.

The *London Sunday Telegraph* said the monkey virus in pre-1963 polio vaccines was "cancer-causing" and might be responsible for causing hundreds of cancer deaths a year among people who were inoculated with the vaccine. ★

Medicine, public health act on disaster response

Members of the Texas Medical Association Council on Public Health and the Texas Public Health Association (TPHA) will meet this month and next month to discuss disaster response and emergency preparedness as part of a $14,650 grant the groups earned from the Medicine and Public Health Initiative's Cooperative Actions for Health Program (CAHP).

The sessions, which will be held during the TPHA Annual Meeting in April and TexMed '99 in May, are designed to reach a wide range of health care professionals, including physicians from the private and public health sectors, nurses, epidemiologists, social workers, vital statisticians, health educators, and local public health officers.

Case studies of the emergency responses to the tornado disaster in Jarrell, Tex, and the bombing in Oklahoma City will be presented, as well as the critical components of the public health infrastructure including:

- The continuum between population-based medicine and the medical approach;
- The differences between population-based medicine and indigent care;
- The impact of managed care on public health and the recent transformation in public health from service delivery to core functions;
- The top 10 causes of death and morbidity;
- The role of local health departments and the need for a competent public health workforce; and
- The role of physician interaction with local public health officers and the role of public health officers as liaisons in the medical community.

For information, call Kristine Niemeyer at (800) 880-1300, ext 1462, or (512) 370-1462; or e-mail kristine_n@texmed.org. CAHP is cosponsored by the American Medical Association and the American Public Health Association. ★

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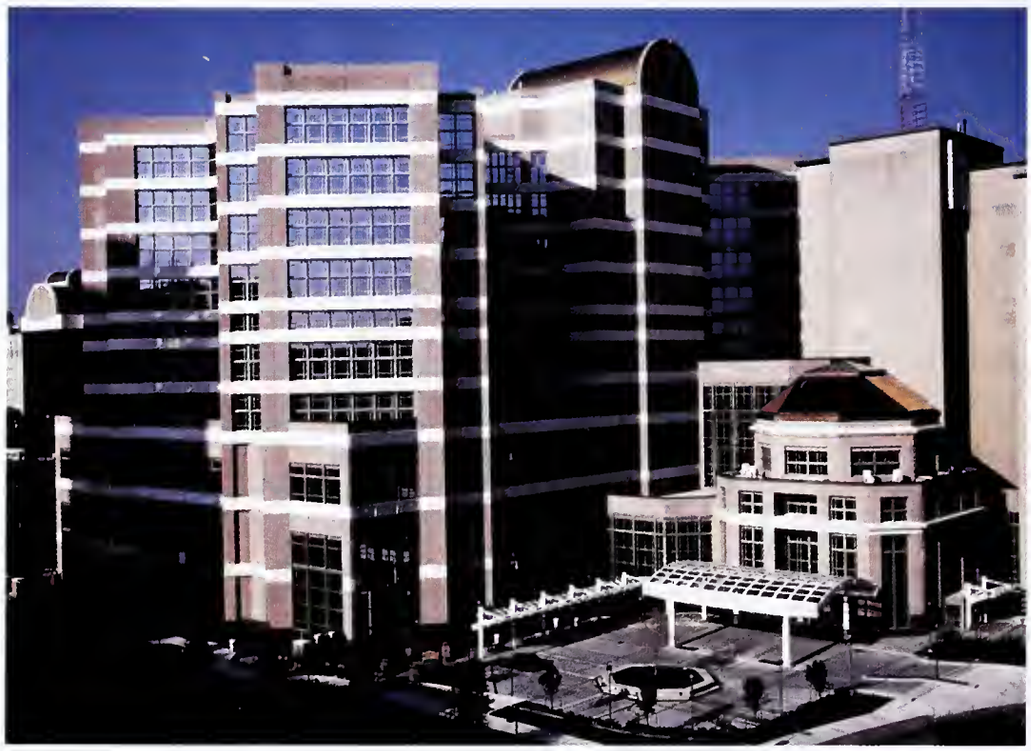

UT M.D. Anderson's Albert B. and Margaret M. Alkek Hospital

M.D. Anderson opens 13-story inpatient tower

More than 120 patients were moved into The University of Texas M.D. Anderson Cancer Center's new Albert B. and Margaret M. Alkek Hospital in early January.

The 13-story Alkek Hospital, which increases M.D. Anderson's central campus to 4.1 million square feet, has nearly 200 private rooms, a 26-bed pediatric inpatient unit, 26 operating rooms designed for the latest technology, a comprehensive intensive care unit, and the latest in diagnostics facilities and pathology laboratories. The new building also houses expanded radiation oncology services and occupational and rehabilitation therapy facilities complete with an apartment for practicing home routines. ★

TIPS ON HOW TO PUT YOUR PATIENTS FIRST

BEST Practices

Texas Medicine **recently received the following anonymous tips from our readers on how to improve the patient-physician relationship.**

- **Organize often to support community issues. Give tetanus shots after a flood. Get on the radio to tell patients where they can get immunizations. At Christmas, collect coats and blankets for the homeless, and give them medical exams.**
- **Conduct straw polls in physicians' offices whereby patients can vote on health care plan policies, benefits, and restrictions. Use this data regarding patient preferences as leverage with health maintenance organizations that attempt to limit appropriate care.**
- **Have managed care organizations educate patients regarding updated and viable physician lists, with special reference to independent physician associations within the managed care organization.**

Please send your suggestions for putting patients first and improving patient-physician communication to president@texmed.org.

Don't just read us — write for us!

Texas Medicine is looking for a few good scientific articles to be published in the magazine's Journal section. Submissions for the section must be high-quality, preferably Texas-specific review articles or original observations of particular interest to the broad range of Texas physicians. They may deal with medical, public health, social, or economic issues related to the health and well-being of Texans.

Material for the Journal section may be sent to the Managing Editor, *Texas Medicine,* 401 W 15th St, Austin, TX 78701. Articles are screened for appropriateness for *Texas Medicine.* Those selected for peer review are reviewed by consultant specialists and an editorial committee, and accepted or rejected on the basis of individual merit, appropriateness, and the availability of other material. Reviews usually take 10 to 12 weeks.

For more information, call Larry BeSaw at (800) 880-1300, ext 1383, or (512) 370-1383; or e-mail larry_b@texmed.org. Also, see "Information for Authors" on p 71. ★

Free videos extinguish tobacco use in kids

The Harris County Medical Society videotaped a recent visit by "The Extinguisher," the American Medical Association's antitobacco superhero, to promote awareness in children, protect them from the dangers of tobacco, and prevent them from starting the habit. County medical societies may order multiple copies of the free video, which lasts 7 minutes and 30 seconds, from the Texas Medical Association.

"The Extinguisher," along with "Dr Nola Know" and students from Houston's MacGregor Elementary School, discusses on the video how kids can fight tobacco and tobacco advertising, how smoking affects the body, and how kids can prevent their friends from lighting up. The video, which targets third and fourth graders and is a good educational tool for physicians visiting schools, also includes the following statistics:

- In the United States, 3,000 kids a day light up for the first time.
- Nine out of 10 people who smoke began the habit when they were kids.
- The average age people begin smoking is 13 years old.
- More than 90% of 6-year-olds recognized Joe Camel and could link him with cigarettes. This equals the percentage of 6-year-olds who recognize Mickey Mouse.

TMA has 100 videos, so order them while supplies last by calling Megan Haley at (800) 880-1300, ext 1464, or (512) 370-1464; or by e-mailing megan_h@texmed.org.

The video's label reads, "The Extinguisher: Anti-Tobacco Message from the Physicians in Harris County." County medical societies that would like to change the label to include their names must pay a fee of $50. ★

Commentary: Multiple thoughts about multiple births

By John C. Jennings, MD

Last year's birth of octuplets in Houston was celebrated with mixed feelings. The community and the medical profession rallied to support the parents and the eight newborns. There is no doubt that the simultaneous birth of so many infants is phenomenal and worthy of the publicity. But the event also raises complex questions that the medical community and society in general must address.

Assisted reproductive technology has advanced rapidly and has made fertility possible for many people who otherwise would remain childless. Patients and physicians share the desire for a healthy and uneventful pregnancy culminating in a healthy child. Our increased knowledge of the mechanisms of ovulation, fertilization, and implantation can reduce the risk of abnormalities of pregnancy. Techniques are becoming widely available to patients, success rates have increased, and insurance carriers have made coverage available for specific infertility treatments. Neonatal care has advanced to a level where very premature infants who are products of the fertility technology survive. The direct beneficiaries of assisted reproductive techniques are many fortunate parents and children.

As with most medical advances, there are downsides and risks. Financial resources required to develop and execute infertility technology are limited. Insurance companies are understandably reluctant to cover advanced infertility treatment that can result in high-risk pregnancies, neonatal intensive care, and enormous ongoing medical costs.

Assisted reproduction also creates ethical dilemmas, such as multifetal reduction, that are difficult to resolve. It is nearly impossible for a desperate, infertile couple to resist achieving pregnancy even at great risk. Ovarian hyperstimulation can be life-threatening, but most of the major maternal and fetal risks are associated with multiple pregnancy. Poor outcomes have been variously blamed on inadequately trained physicians, misuse of ovulation-induction medications, and lack of resources for monitoring patients. The American Society for Reproductive Medicine is continually revising and proposing guidelines that address these issues.

The psychological, physical, and financial risks associated with assisted reproduction should be thoroughly understood by all participants. It is obvious that further research is needed to improve the outcome of these techniques. Excessive regulation of reproductive technology likely can be avoided by the responsible development and safe delivery of infertility services by the medical profession. The birth of octuplets should be a rare event and is mostly preventable. The best outcome of assisted reproductive technology is a single healthy baby.

Dr Jennings is a professor and regional chair of the Department of Obstetrics and Gynecology at the Texas Tech University Health Sciences Center in Amarillo. He also is chair of the *Texas Medicine* Editorial Committee.

Forum On Ethics

Compassion by the bedside

By Fazlur Rahman, MD

As an oncologist, sometimes I have to take a disconcerting stand — a stand against giving chemotherapy to certain patients. An 82-year-old woman presented with acute myeloid leukemia (AML) and its complications — bleeding, infection, and anemia. Her husband had died of the same disease after protracted treatments and suffering. That experience weighed heavily on her daughter and son, who now asked for only palliative care. The patient and I agreed with her children. Many oncologists, in fact, are against treating AML in this age group because complications of therapy are harsh, and many patients never recover from these complications.

I referred her to a hospice program. Then came the dilemma: her granddaughter, a nurse in a large teaching hospital, intervened. She disagreed with our approach and demanded chemotherapy treatment. "Everyone, young or old, should be given a chance," she said.

The poor woman was in a terrible quandary, but she adored her granddaughter and did not want to disappoint her. "I am going to die anyway," the patient said. "Let me just try one treatment. What have I got to lose?"

We go to great lengths to please our loved ones, at times to our detriment. I sensed this was such a case. I reiterated my worries about the undue distress from the agonizing side effects. The patient understood my position, and I urged her to rethink her decision. If she was still firm in her belief, I would start chemotherapy the next morning.

More than 20 years of practicing oncology has taught me that restraint is also part of compassion.

The next morning, however, she was ready to spend her last days at home under hospice care. She lapsed into a coma and died 3 days later, most likely due to cerebral hemorrhage caused by severe thrombocytopenia.

This patient's condition raises a question that we can't ignore. The 80-plus age group is the fastest growing population in the United States, and cancer is a significant problem for them. Breast cancer is the most common cancer in women. While early breast cancer is a curable disease, metastatic breast cancer is a relentless condition. Hormones such as tamoxifen and the like are well-tolerated, but chemotherapy brings up a host of problems. The same issues apply to men as well: prostate cancer is the No. 1 cancer in men, and for hormone-refractory prostate cancer, there is very little effective chemotherapy, serious toxicities aside.

Complex academic treatises on ethical, moral, and medicolegal principles of patient care are fine in theory, but clinicians have to make decisions at patients' bedsides, one patient at a time. They can't be guided by abstract ideas. And they have to consider the possibility of worsening their patients' quality of life from treatments, regardless of the prevailing sentiment.

Over the years, I have had a metamorphosis in my own thinking. After coming out of training, I felt that *all* patients needed active, not necessarily heroic, measures. After all, that's why they were sent to a specialist. But more than 20 years of practicing oncology has taught me that restraint is also part of compassion.

We should remember that age is only one factor in deciding about chemotherapy. Functional status and the type and extent of the malignancy have more important bearings. Most adult patients of any age understand what they are facing, and they accept or reject therapy after knowing the facts.

Rare individuals and their families, however, will not acknowledge adverse diagnoses, prognoses, or treatment limitations, no matter what. All reasoning will be futile, and they will go from place to place in search of a cure despite their daily ordeal. But that is their choice, as it should be.

A 58-year-old woman with poorly differentiated endometrial cancer was referred to me for relapse, with extensive intraabdominal metastasis, massive as-

Dr Rahman is an oncologist in San Angelo and a member of the *Texas Medicine* Editorial Committee.

Texas Medicine welcomes comments about issues discussed in the Forum on Ethics. If you would like to comment or submit a column for possible publication, please contact Teri Moran, senior editor, at *Texas Medicine*, 401 W 15th St, Austin, TX 78701; phone (800) 880-1300, ext 1371, or (512) 370-1371; fax (512) 370-1632; or e-mail teri_m@texmed.org. Proposed columns must be no longer than 900 words and written in a case study format.

cites, pleural effusion, and dyspnea. (Surgery and radiation already had failed her.) Paracentesis and diuretics relieved some of her symptoms. Then she received the first course of chemotherapy, which made her very sick. And even with the treatment, her disease progressed. Informed of the ineffectiveness of further chemotherapy and the dangers of cumulative toxicities, she chose hospice. But her brother, who initially stayed away from her bedside, now came to take part in her care. "Not giving any more treatment means you have given up on her," he said. He enumerated his own findings gathered through the Internet: the ways to cure cancer with such and such methods, and that it was just a matter of going to the right place. He then took his sister to Mexico.

Would it have been better to continue some sort of treatment to sustain her and her family's hope? At times, it's an almost insurmountable problem to solve: how do you tell a patient she or he is "terminal" without taking away hope? Hope, as we all know, is an essential part of medical care. Yet false hope can undermine patients' confidence in their doctors.

We all want the best for our patients, and it's not an easy task to be detached emotionally while making medical judgments. Still, we do a disservice to patients and often put them through unnecessary trauma by not being frank with them.

Reflect on these facts: the vast majority of patients with cancers of the lung, pancreas, and stomach; advanced melanoma; and resistant colon cancer fare no better than the victims of progressive breast and prostate cancers. They have short lives with long hurdles.

So what does all this mean? I believe that under particular circumstances, we are obligated to discourage active cancer treatment. Our overriding concern then must be to improve the quality of the patient's remaining life.

Author's acknowledgments: I am indebted to Gulshan Rahman and Yasmin Rahman for their encouragement and for sharing their ideas with me; and to Susanne Tripodi and Lea Henderson, RN, OCN, for their assistance. ★

Cancer journal recipients must resubscribe

Because of a publisher change, subscribers who want to continue to receive *CA – A Cancer Journal for Clinicians,* must resubscribe. A peer-reviewed journal that covers all aspects of cancer management and serves as a professional education vehicle for the American Cancer Society, *CA – A Cancer Journal for Clinicians* is written for the clinician in primary care, oncology, and related specialties.

Subscriptions for the bimonthly journal are still free and can be requested by calling the American Cancer Society at (888) ACS-5552, by e-mailing journals@cancer.org, or by writing to Publishing Director, American Cancer Society, 1599 Clifton Rd NE, Atlanta, GA 30329. Include your name, title, clinical specialty, address, and e-mail address in your subscription order. The journal also is available on the Internet at www.ca-journal.org. ★

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TMA FOUNDATION

Uniting the profession

Medical specialties unite to fight optometry's encroachment into medical practice

Artman

Two years ago, legislation to allow Texas optometrists to treat glaucoma and perform some surgical procedures on the eye never made it to the House or Senate floor for debate. But that has not discouraged optometrists from aggressively pursuing a similar agenda this year.

Legislation has been filed in the 76th Texas Legislature to authorize what ophthalmologists are calling a dangerous expansion of optometrists' scope of practice. And, physicians from specialties such as family practice, dermatology, oncology, surgery, internal medicine, and pediatrics are closing ranks with ophthalmologists to fight what they see as a serious threat to the vision and health of Texas eye patients.

By Ken Ortolon, Associate editor

Kim Ross, vice president for public policy for the Texas Medical Association, says the pending debate in Texas is being played out in virtually every state legislature across the country. And, optometrists are backing their play with all the political muster they can assemble.

"Optometry, perhaps more so than any other allied health profession, continues to pursue through the ballot box quasi-medical legal status," Mr Ross said.

Optometrists scored a major victory last year when Oklahoma became the first state to allow them to perform laser surgery. That success likely will bolster their arguments before the Texas Legislature.

Setting the agenda

Two bills filed by State Rep Kim Brimer (R-Arlington) would radically expand optometrists' scope of practice to include full medical treatment and management of glaucoma with no physician input and grant them authority to perform 17 specific surgical procedures that do not involve the use of lasers. Furthermore, the bill gives the Texas Optometry Board unprecedented authority to decide what is within optometrists' scope of practice and set the standards for who can perform these new duties.

Finally, one of the bills requires the University of Houston College of Optometry and The University of Texas-Houston Health Science Center to conduct a study of the efficacy of allowing optometrists to perform laser surgery. Ironically, the Houston medical school did not ask to be part of the study.

The measures are almost identical to those filed in 1997 on optometry's behalf and would put Texas on the list with only six other states that allow optometrists to treat glaucoma. In a video produced to help support the 1997 legislation, optometrists argued that the state's "outdated" optometry act prevented them from providing all the care they are trained to provide and that optometrists are on a level playing field with physicians with regard to the use of lasers.

"Optometrists are educated and trained to care for most of the people's problems most of the time, including external eye disease, glaucoma, and the use of lasers," said Jerald Strickland, OD, PhD, dean of the University of Houston College of Optometry, in that video.

Houston ophthalmologist Jeffrey D. Lanier, MD, says the "training" optometrists receive falls well short of what ophthalmologists receive and well short of what they need to competently perform the procedures or to use the drugs for which they're asking.

"The problem here is they have trained themselves," said Dr Lanier, who was part of the negotiating team for the Texas Ophthalmological Association (TOA) during the last legislative session. "They haven't gone to medical school, they haven't had any training in ophthalmology, and yet they keep increasing what they feel their abilities are by training themselves."

Dr Lanier receives frequent referrals from optometrists and believes they are well trained for their current role in eye care. He also occasionally lectures on issues such as infectious diseases at the University of Houston optometry school. But he says lectures cannot replace the hands-on clinical experience needed to diagnose adequately and treat complex diseases of the eye.

"You can't learn medicine listening to a lecture or reading a book," Dr Lanier said. "You have to see tons of pathology and tons of patients to appreciate all the extreme ramifications of clinical signs and the disease presentations. The analogy I use is, it's like 120 people sitting somewhere watching someone play the piano. You'll never learn to play the piano that way."

Ignorant of ignorance

Dr Lanier says optometrists simply "don't know what they don't know." That was well demonstrated during the 1997 negotiations between optometrists and ophthalmologists when Dr Lanier asked one of optometry's representatives how he would treat a corneal laceration. The optometrist replied that he would suture it with a silk suture.

"Well, I've been a corneal surgeon for 25 years, and I've never seen anybody put a silk suture in the cornea because there's just too much reaction and you get too much scarring," Dr Lanier told the optometrist. That exchange was witnessed by and appeared to have quite an impact on the chair of the House committee that considered that bill, Dr Lanier adds.

> "They haven't gone to medical school, they haven't had any training in ophthalmology, and yet they keep increasing what they feel their abilities are by training themselves."

Optometrists also argued in their 1997 video that access to eye care would be improved greatly by granting additional authority to optometrists because large areas of the state have no access to ophthalmologists. Jay Propes, TOA executive director, says, however, that more than 95% of Texas has access to an ophthalmologist within a 50-mile radius.

"Our position is that the state has no compelling need to lower the quality of eye care by lowering the standards for eye care providers in the name of increased access," Mr Propes said.

The Oklahoma experience

These same arguments were made against optometry's bill in Oklahoma to no avail. Optometrists there actually had been performing laser procedures for several years before a 1997 court ruling that held laser surgery was beyond their legal scope of practice.

In the wake of their significant victory in the courts, Oklahoma physicians were caught off guard when legislation was filed to restore that au-

All articles in *Texas Medicine* that mention Texas Medical Association's stance on state legislation are defined as "legislative advertising," according to Texas Govt Code Ann §305.027. That law requires disclosure of the name and address of the person who contracts with the printer to publish the legislative advertising in *Texas Medicine*: Louis J. Goodman, PhD, Executive Vice President, TMA, 401 W 15th St, Austin, TX 78701.

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This ad paid for by Jim Mallios and Joe K. Longley.

thority; optometrists already had considerable support for their bill before organized medicine could sufficiently counter its attack.

Edmond, Okla, ophthalmologist Jeffrey T. Shaver, MD, then the president of the Oklahoma Academy of Ophthalmology, says that's because optometrists were driving a "well-oiled political machine" when they pushed their bill through the Oklahoma Legislature in 1998. In an article published in the August 1998 issue of the *Review of Ophthalmology,* Dr Shaver said optometrists had been laying the political groundwork for their success for years.

"Optometrists here have worked very hard to get close to their legislators," he wrote. "They've made friends, held fundraisers, and helped them campaign for office."

Brian Foy, executive director of the Oklahoma State Medical Association (OSMA) agrees. "They are very politically savvy, as are most of the allied health organizations," Mr Foy said. "They believe in the political process, they get involved, they participate locally, they get to know their legislators, and, when they need something, they go for it. They've built the kind of legislative relationships we in the physician community have never been as successful at."

Mr Foy says OSMA fought the bill with assistance from TOA, Mr Propes, the Oklahoma Academy of Ophthalmology, the New Mexico Academy of Ophthalmology, the American Academy of Ophthalmology, and the American Medical Association but could not overcome optometry's head start.

"It was clearly a sinking ship," Mr Foy said. "We did everything we could but the legislators had already made up their minds. Politics won out over science."

The Oklahoma bill gives optometrists the authority to perform any laser surgical procedure not expressly prohibited by the bill, including glaucoma surgery, YAG capsulotomy, and photo refractive keratectomy.

Preventing a repeat

TMA physician leaders and lobbyists warn that optometrists are just as well organized here in Texas. We could see a

repeat of the Oklahoma situation unless physicians unify to use their political clout to counter that of the optometrists, they say.

Toward that end, TMA and TOA are working with other medical specialties to present a united front to lawmakers. Mr Propes says medicine's message is simple. "A patient goes to see somebody in a white coat called the doctor. He or she doesn't know if the doctor is a doctor of this or a doctor of that, but the patient expects the state to protect him or her. We've got to make sure that the person called the doctor is doing only what he or she is trained and competent to do."

In a letter sent to every member of the legislature, Robert W. Sloane, Jr, MD, of Fort Worth, chair of the TMA Council on Legislation, said, "We strongly oppose this attempt to achieve status through political effort rather than through rigorous and extensive training."

Troy Alexander, who until recently served as director of legislative and public affairs for the Texas Academy of Family Physicians, says family practitioners are concerned with the across-the-board push of allied health professionals to expand their scope into the realm of medical practice.

"We are concerned because when one area of allied health expands its practice, it only helps other areas make their case to infringe on the practice of medicine," Mr Alexander said. "We see the threat by optometrists as a threat to family practice."

Mr Alexander says it's crucial for medicine to stick together on this issue to protect the public, something Dr Shaver says Oklahoma ophthalmologists failed to do.

"If medicine doesn't stand together on these cases, then one by one they will be picked off until the practice of medicine is compromised across the board," Mr Alexander said.

Even if medicine succeeds in beating back this year's legislation, optometrists won't quit, Dr Lanier adds.

"They are going to keep coming back until they make headway and they will make headway when they have the right people in the right spots in the legislature," Dr Lanier said. ★

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Do I really do what I say I do?

Texas heart doctors find out for themselves

Ever known any physicians just itching for a chart audit of their own records and whose eyes literally light up at the mere mention of one? Look no further than at a group of Texas physicians who are so gung ho to battle the No. 1 killer of Americans they can't wait to spread the gospel of a trailblazing program called the HeartCare Partnership. ➤➤

By Teri Moran, Senior editor

Designed for physicians to better their medical management of patients who have cardiovascular disease, HeartCare is a joint project between the American Heart Association (AHA), Texas Affiliate, and the Texas Medical Association, with support from Merck Pharmaceuticals.

Unlike some programs of dubious value that are imposed on physicians by government or hospital administrators, HeartCare is physician led, from A to Z. Doctors decide what's important in managing patients with cardiovascular disease and then they figure out the best way to go about doing it and making sure it gets done.

No mystery to secondary prevention

By following a few relatively simple therapeutic steps, patients who have had a heart attack or some other acute event can reduce drastically their chances of having a second one. It's common medical knowledge that the AHA issued guidelines in 1995 outlining those steps (see "Comprehensive Risk Reduction for Patients with Coronary and Other Vascular Disease," p 40). They include measures as simple as telling patients to take aspirin daily and exercise. In fact, low-tech therapies seem to have the greatest impact on morbidity and mortality.

One study of 150,000 elderly Medicare patients who were hospitalized between 1995 and 1997 was published in the January 28, 1999, issue of *The New England Journal of Medicine.* Researchers found that patients with cardiovascular disease who were treated in the top 60 hospitals, as measured by *US News & World Report,* had a significantly lower mortality rate than patients treated in other hospitals. But apparently, the reason patients fared better in those hospitals, researchers said, was simple — greater use of beta-blockers and aspirin.

Secondary prevention of cardiovascular disease doesn't take a lot of exotic testing or fancy medicine, says Dallas cardiologist Melbert Hillert, MD, chair of the HeartCare subcommittee under TMA's Committee on Cardiovascular Diseases. "What it takes is physicians paying attention to the basics of care," he said.

"If a hospital in Texas wants to be ranked among the top 40 US hospitals in cardiovascular care, all the medical staff has to do is pay attention to risk factor modification," Dr Hillert said. "We already know from published, large clinical trials that these preventive measures work."

How HeartCare works

In a nutshell, a cardiologist attends a seminar, ideally with a nurse and family physician with whom he or she works. Then the team goes back home to implement its own self-designed, tailor-made program. The seminar is accredited for 4 hours of Category 1 continuing medical education (CME) credit.

Using AHA guidelines, physicians are asked to audit 50 patient charts and bring the results to the seminar, which gives them and/or their institutions a benchmark. Using an interactive approach to CME rather than straight lecture, HeartCare facilitators work with the teams to custom-design a program that meets their needs.

"Then, we go home and incorporate AHA guidelines into our routine practice of medicine," said Houston cardiologist A. Tomas Garcia III, MD, who chairs TMA's Committee on Cardiovascular Diseases. "And based on that first chart audit, we can see whether we're improving when we audit again in 3 months or 6 months."

Dr Garcia bemoans how physicians seem to get "hung up" on the chart audit aspect of the program, even though physicians audit themselves on the honor system if they want to. "The chart audit's not the problem. The issue is whether we are doing what's proper for our patients."

Dr Hillert says his first self-audit was somewhat disconcerting. "You realize you have to intensify your focus and make sure you pay attention to the risk factors." He said he and other cardiologists found that they weren't testing for LDL cholesterol levels often enough. And even when they did, they often didn't push hard enough to get levels lowered with medication or by urging patients to exercise and eat right. "You have to emphasize it to patients and monitor them, and they must be partners with the health care team."

HeartCare is focused, above all, on a team approach, but it is physician led. "This is a grassroots effort; we're working from the ground up," Dr Garcia said. "We know what we're supposed to be doing. The rubber meets the road when we can look at ourselves and honestly answer the question, 'Well, are we doing it?'"

"The chart audit's not the problem. The issue is whether we are doing what's proper for our patients."

Self-evaluation is used as a guide to achieve targeted goals, Dr Hillert says. "There's no one telling us to do this — not the federal government, not the insurance companies, not anyone else. It's physicians themselves with TMA and AHA."

In other words, physicians are taking back medicine, Dr Hillert said. "That's the important part. Through evidence-based medicine, through trying to close the treatment gap, we can now have the documentation to prove to the world that we are doing what's right."

TMA's House of Delegates voted to support the HeartCare Partnership during its interim session last November. A few Merck-sponsored programs already had begun in Houston and Dallas in late 1997. But the first pilot program of the three-member partnership began in Lubbock last December. The second began in Dallas in February.

HeartCare Partnership is gaining momentum, thanks in part to its enthusiastic champions such as Drs Hillert and Garcia, but also because of its demonstrable benefit to patients.

"Our ultimate goal will be that once we can take the best care of people who have proven disease, then we can expand into the even more difficult area of primary prevention, said Dr Hillert." ★

Comprehensive risk reduction for patients with coronary and other vascular disease

Consensus Panel Statement

Preventing heart attack and death in patients with coronary disease. *Circulation*. 1995;92:2–4.

Risk Intervention	Recommendations
Smoking: Goal complete cessation	Strongly encourage patient and family to stop smoking. Provide counseling, nicotine replacement, and formal cessation programs as appropriate.
BP control: Goal <140/90 mm Hg or <130/85 mm Hg if heart failure, renal insufficiency or diabetes.	Initiate lifestyle modification — weight control, physical activity, alcohol moderation, and moderate sodium restriction — in all patients with blood pressure ≥130 mm Hg systolic or 85 mm Hg diastolic. Add blood pressure medication, individualized to other patient requirements and characteristics (ie, age, race, need for drugs with specific benefits) IF blood pressure is not less than 140 mm Hg systolic or 90 mm Hg diastolic OR if blood pressure is not <130 mm Hg systolic or 85 mm Hg diastolic for individuals with heart failure, renal insufficiency, or diabetes.
Lipid management: Primary goal LDL <100 mg/dL Secondary goals HDL >35 mg/dL; TG <200 mg/dL	Start AHA Step II Diet in all patients: ≤30% fat, <7% saturated fat, <200 mg/d cholesterol, and promote physical activity. Assess fasting lipid profile. In post-MI patients, lipid profile may take 4 to 6 weeks to stabilize. Add drug therapy according to the following guide:

LDL <100 md/dL	LDL 100 to 130 mg/dL		LDL >130 mg/dL	HDL <35 mg/dL
No drug therapy	Consider adding drug therapy to diet, as follows:		Add drug therapy to diet, as follows:	Emphasize weight management and physical activity. Advise smoking cessation. If needed to achieve LDL goals, consider niacin, statin, fibrates.
	Suggested drug therapy			
	TG <200 mg/dL	TG 200 to 400 mg/dL	TG >400 mg/dL	
	Statin Resin Niacin	Statin Niacin	Consider combined drug therapy (niacin, fibrates, statin)	
	If LDL goal not achieved, consider combination drug therapy.			

Physical activity: Minimum goal 30 minutes 3 to 4 times per week	Assess risk, preferably with exercise test, to guide prescription. Encourage minimum of 30 to 60 minutes of activity 3 or 4 times weekly (walking, jogging, cycling, or other aerobic activity) supplemented by an increase in daily lifestyle activities (eg, walking breaks at work, gardening, household work). Maximum benefit 5 to 6 hours a week. Advise medically supervised programs for moderate- to high-risk patients.
Weight management: Goal BMI 21–25 kg/m²	Measure patient's weight and height, BMI, and waist-to-hip ratio at each visit as part of routine evaluation. Start weight management and physical activity as appropriate. Desirable BMI range: 21–25 kg/m². Desirable waist circumference <40 inches in men and <36 inches in women.
Diabetes management: Near normal fasting plasma glucose and near normal HbA1c (<7)	Appropriate hypoglycemic therapy to achieve near normal fasting plasma glucose as indicated by HbA1c. Treatment of other risks (eg, physical activity, weight management, blood pressure, and for cholesterol management, see recommendations above).
Antiplatelet agents/ anticoagulants:	Start aspirin 80 to 325 mg/d if not contraindicated. Manage warfarin to international normalized ratio = 2 to 3.5 post-MI patients not able to take aspirin.
ACE inhibitors post-MI:	Start early post-MI in stable high-risk patients (anterior MI, previous MI, Killip class II [S_3 gallop, rales, radiographic CHF]). Continue indefinitely for all with LV dysfunction (ejection fraction ≤40%) or symptoms of failure. Use as needed to manage blood pressure or symptoms in all other patients.
Beta-blockers:	Start in high-risk post-MI patients (arrhythmia, LV dysfunction, inducible ischemia) at 5 to 28 days. Continue 6 months minimum. Observe usual contraindications. Use as needed to manage angina, rhythm, or blood pressure in all other patients.
Estrogens:	Estrogen replacement: individualize consistent with other health risks.

ACE indicates angiotensin-converting enzyme; MI, myocardial infarction; TG, triglycerides; and LV, left ventricular.

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TexasMedical Association

PHYSICIAN ONCOLOGY POEP EDUCATION PROGRAM

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A NEW APPROACH. PHYSICIANS LEARN TO BETTER CARE FOR THE DYING.

BY TERI MORAN, SENIOR EDITOR

THOUSANDS OF YEARS AGO, a sage old man said that it is better to go to a house of mourning than to a house of feasting, "for death is the destiny of every man; the living should take this to heart." That adversity is more instructive than happiness was probably the aged King Solomon's main point in Ecclesiastes 7:2. But his advice also could suggest the folly in denying death or fighting it overmuch — something of which both American culture and American medicine are guilty.

Studies have shown that medicine has fallen short in caring for dying patients. According to one 8-year study of 10,000 critically ill patients, too many die alone, in unnecessary pain, and while receiving unjustifiably aggressive care. That same study, published in the November 22-29, 1995, issue of *The Journal of the American Medical Association*, found that too many physicians either misunderstand or ignore their dying patients' treatment wishes.

Cultural forces are pushing end-of-life care onto center stage — a culminate example being televised euthanasia à la Dr Jack Kevorkian — proving that American society is thinking about the dying process and looking for improvements.

Recognizing that need, medicine has begun to teach physicians how to improve their dying patients' care. ➤➤

Systematic approach

One notable example is the American Medical Association's Institute for Ethics Education for Physicians on End-of-life Care (EPEC) program. (See "Improving End-of-life Care: A Challenge for the Profession, p 46.) Physicians who complete the 2-day course, which was launched in January, learn everything from hands-on palliative medicine to how to break bad news to patients. "It is very much a train-the-trainer program," said Linda Emanuel, MD, PhD, director of AMA's Institute for Ethics. "For it to be successful, participants must take what they learn and share it with others."

Texas Medicine spoke with three Texas physicians who were among the first EPEC "graduates" and with Ira Byock, MD, past president of the American Academy of Hospice and Palliative Medicine and author of *Dying Well: The Prospect for Growth at the End of Life.*

"What's wonderful about this program is that it goes beyond just addressing deficiencies," Dr Byock said. "It really provides a framework in which physicians can serve their patients and their families in a way that is satisfying and that truly integrates end-of-life care into the mainstream of physicians' practices."

Although their reasons for it vary, the physicians *Texas Medicine* interviewed share a commitment to improve end-of-life care in their own practices and, after attending EPEC, to help other physicians do the same.

Lack of training

Fort Worth internist Kendra Belfi, MD, vividly recalls her days as a medical student almost 30 years ago in Dallas, doing code after code on dying heart patients. "You just kept trying, because the emphasis was on doing everything you could to save lives. There wasn't any guidance for when you had hit a futile situation." Such attitudes were born of that era's technological medical revolutions, Dr Belfi says. "People in my generation were taught how to do everything *but* wind things down and transition into palliative care or comfort care."

Jump ahead a couple of decades to the late 1980s when San Antonio pediatrician, internist, and palliative care specialist Dennis Pacl, MD, did his residency. "In 4 years, I recall just one lecture about care at the end of life, and it didn't include pain management," Dr Pacl said, describing such lack of training as typical for the times. "It's not that physicians practicing now aren't sensitive to their patients' needs, it's just that they haven't been taught how to deal with dying patients."

At least now, hospice programs are widespread and physicians do refer patients to them, Dr Pacl says, but usually many months later than they could. "The typical hospice patient spends just 2 weeks in hospice care before dying, when hospice is designed for patients in their last 6 months of life."

It's the insidious, cyclical nature of disease and the ubiquitous death-denial mindset in patients' families that keep patients "in and out of hospitals getting ineffective care," Dr Pacl said. "You can't always call it completely futile care either," he added, because conventional medicine leads physicians to believe that somehow, through careful medical management, they might add a few quality days of life to those patients with NYHA Class IV heart failure. "Symptom management is only a small part of what the patients need as they approach life's end."

"It's not that physicians practicing now aren't sensitive to their patients' needs, it's just that they haven't been taught how to deal with dying patients."

Public expectations

Physicians didn't resuscitate 80-year-old people repeatedly to be goulish, but because that was the scientific and public mindset, according to San Antonio pediatric oncologist Javier Kane, MD. "For ages, medicine could do next to nothing for patients. And then the wonders of new technology gave us the ability to cure disease and prolong life."

But along with scientific advancement came what Dr Kane calls the separation of the objective and subjective, where science dealt with the body and disease, and religion dealt with the mind and spirit. "Our culture views death as a medical problem that should be solved — a technical problem that requires a technical solution — instead of seeing it as a mystery that we all should learn to witness and experience." Such dichotomous thinking is "very hard for all of us to let go of," he says, because our culture has thought that way for so long.

Dr Byock says denial of death is still rampant. "It's a constant that runs through the confused and conflicted way Americans approach life's end. We don't want to admit that dying is happening even when it is right in front of us. We sometimes don't attend to even the basic needs of our loved ones because we are unable or unwilling to accept that their time is short."

Because everybody involved may conspire to deny that Grandpa, who has cancer and advanced heart failure, is dying, the tendency is to put him in the hospital when he has problems, Dr Byock says. "Then the doctors are exhorted to do something to correct the current problem, whether it be

TexMed '99 offers physicians end-of-life training

The 2-day Education for Physicians on End-of-life Care (EPEC) program will be offered May 6–7 at TexMed '99 Educational Showcase & Expo at the Wyndham Anatole Hotel in Dallas. For more details, see the TexMed Web site at virtual.texmed.org.

fever or chest pains or breathing problems. And then where does he die? In a hospital, surrounded by the bleeps and hisses of machines, with strangers poking him, instead of being surrounded by the ones he loves, perhaps listening to children playing outside."

> "We don't want to admit that dying is happening even when it is right in front of us. We sometimes don't attend to even the basic needs of our loved ones because we are unable or unwilling to accept that their time is short."

Denial often becomes even more pronounced when children face death, Dr Kane says, because children are supposed to outlive their parents. He would like to see EPEC include a pediatric module, and at this year's TexMed '99, May 6–9, at the Wyndham Anatole Hotel in Dallas, a pediatric module may be included in the EPEC seminars.

Family communications

Most physicians at one time or another have encountered the kind of case Dr Pacl describes that shows the difficulty of breaking down the wall in the dying process that separates science and humanity — even in a family with good communication.

A 70-year-old man had been robust all his life and was still running 3 miles a day when nagging chest pains drove him to the hospital where he was diagnosed with adenocarcinoma of an unknown primary site. When Dr Pacl was called in as a pain management consultant, the patient had been hospitalized for several weeks, was in the intensive care unit, and was being urged to consider chemotherapy. Although board-certified in palliative care, Dr Pacl had trouble managing the man's severe pain, and

Improving end-of-life care: A challenge for the profession

The Education for Physicians on End-of-life Care (EPEC) Project, supported by a grant from the Robert Wood Johnson Foundation, is an ambitious, 2-year initiative designed to educate physicians across the United States on the essential clinical competencies in end-of-life care that every physician should have. Housed within the End-of-life Care Section of the American Medical Association Institute for Ethics, the EPEC Project involves several complementary components. At the heart of the project is a standardized core curriculum that will train physicians in the basic knowledge and skills they need to appropriately care for dying patients.

The EPEC Curriculum, which has been designed with input from nationally respected experts in the field, combines didactic sessions, videotape presentations, interactive discussions, and practical exercises in a 2-day conference format. Consisting of four 30-minute plenary modules and twelve 45-minute workshop modules, the curriculum is uniquely practical, transportable, and self-contained. It teaches fundamental skills in communication, ethical decision-making, palliative care, psychosocial considerations, and symptom management.

There are also several EPEC Project companion products. The first, the EPEC Speakers List, is a detailed listing of recommended individuals who are available to speak on topics related to end-of-life care. Accompanying each name will be information about the speaker's background and expertise, suggested content areas and titles, and presentation style. A second product, the EPEC Resource Guide, is also intended to assist organizers of educational programs on end-of-life care. This guide provides an annotated list of resource materials and how to obtain them. These products are available upon request or on the AMA's Web site. A third product, the EPEC Compendium, will contain a listing of learning opportunities for physicians within hospices and palliative care units. Finally, a self-directed learning manual called the EPEC Monograph will be developed and made available to physicians across the country this year. Physicians who complete the monograph's self-directed learning program will be eligible to apply for continuing medical education credit.

For more information on the EPEC Project or EPEC Team, see AMA's Web site at www.ama-assn.org/ethic/epec, or write or call:

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a meeting of his physicians and family members was held to discuss his care.

"The patient had made it clear to me how he wanted to spend his last few weeks of life, and it didn't include the added agony of chemotherapy," Dr Pacl said. "He was scared to death because he didn't want his family to think he was giving up by refusing chemotherapy."

At the meeting, Dr Pacl gently advocated on his patient's behalf, and everyone agreed hospice care was the best choice. When that stressor was eliminated, the patient's pain control improved immediately.

Dr Pacl says it has been his experience that you cannot always get patients' pain under control unless you address their social suffering as well. That suffering often is exacerbated by the death-denial thinking of families, he adds, and, in cases too numerous to count, is worsened when patients are unconscious and cannot make their own decisions.

Although the case he relates had an uncommonly good ending, as death experiences go, it also qualifies as a common example of what happens to someone diagnosed with an incurable disease. "One thing leads to another and the patient gets drawn down the road of escalating care and treatment-related morbidity in our medical system," he said.

Fullness of life in death

To put the brakes on escalating, painful, and often futile treatment, physicians must be prepared to look at the big picture, Dr Kane says. "That's what we need to learn to do — to combine science and our competency in treating disease with compassionate medical care."

As disease progresses and death is inevitable, physicians must change from a position of science and having to do something for the patient "to the position of being with the patient and keeping him or her from pain as much as possible," Dr Kane said. "It becomes a personal experience." It's a simple matter of shifting the goals of care, Dr Belfi says. "It's just a change in thinking. If we know we can't cure them, then we must determine what our patients want from us to enhance the quality of their last days of life. That becomes the new goal."

> "It's just a change in thinking. If we know we can't cure them, then we must determine what our patients want from us to enhance the quality of their last days of life. That becomes the new goal."

Dr Belfi says she came away from the EPEC program with many new tools and skills, including a step-by-step guide to follow when talking to patients about difficult situations. "There was a huge pain module and a section on dealing with symptoms in the last 24 hours of life." The EPEC training also stresses the importance of psychosocial issues that need to be addressed as well as advanced care planning.

Drs Belfi, Kane, and Pacl say that while they regret not having the opportunity to learn such skills in medical school or residency, they hope that progress will continue and are glad to be instruments of it.

Dr Byock pointed out that every medical student takes a monthlong rotation in obstetrics, but only a small percentage of physicians ever care for pregnant women or deliver babies. "When you total what most schools teach about end-of-life care, it's maybe 4 to 10 hours in 4 years. It's ludicrous," he said. End-of-life care as yet does not rate highly in the health care delivery system's economy, Dr Byock says. "Until the public makes it clear that this is not just another issue, it may remain just another 'issue.'"

But medicine is being called upon to exercise leadership and to help society reintegrate dying into the fullness of life, Dr Byock says. As do many other palliative care physicians, Dr Byock says he realizes incredible satisfaction as a clinician in helping patients and their families confront life's end. "It enriches our practices and, in a real way, can return to us the richness that drew us to medicine in the first place." ★

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Right place, right time

Texas medical student helps Colombian earthquake victims

We met at the Red Cross headquarters in Medellin on February 4 to take a bus to Cordoba, the epicenter of the Colombian earthquake of January 25. Most of our group of 17 was already there when I arrived. Ten were Colombian medical students in their fifth of 6 years, three were interns in their last year of school, and three were licensed physicians. I was the "token gringo."

By David Ross

We got a short introduction on what to expect and what our job would entail, and we received letters identifying us as Cruz Roja (Red Cross) volunteers. We were told Cordoba is controlled by the police and the right-wing paramilitary groups, while the countryside where we would be working belongs more to the FARC (Fuerzas Armadas Revolucionarias de Colombia) guerrillas. We also were told, to my relief, that there had been no trouble since the earthquake.

The US State Department had warned US citizens not to travel to Colombia unless necessary because of the dangers from city crime and political violence from both guerrillas and paramilitary forces. These warnings are enough to make you think twice about going there, so during the first couple of weeks I was there, my imagination ran pretty wild about getting mugged, kidnapped, murdered, or caught in guerrilla-army crossfire. Needless to say, I did not personally encounter any of what the State Department described. That isn't to say it doesn't happen because I met people directly affected by the violence of Colombia, either by having a relative murdered or kidnapped or by being displaced by the guerrilla war. I was a bit wary about traveling outside the city even though I wanted to see as much of Colombia as possible. So when the opportunity to go to the area affected by the earthquake arose, I thought it would be a great chance to help as well as a chance to see more of the country in a relatively safe manner.

I was impressed by the beauty of Colombia. It is an incredibly rich country in its geographic and cultural diversity and the spirit of its people. Yet it is still a country that is very poor in many parts. Colombia holds huge potential for prosperity were it not in large part for the guerrillas and paramilitary forces that destabilize the population and economy, plus the corruption and violence generated by the cocaine trade.

Before we left, several members of the group joked about plastering Red Cross letters across our chests to make sure everyone knew who we were. That may not have been a good idea; in nearby Armenia some Red Cross workers were attacked by people thinking they had food and supplies. When the bus arrived with Red Cross symbols on all sides, we loaded up and headed south.

Police were at every corner guarding against looting. The most disturbing parts were the sidewalks and open spaces filled with makeshift shacks made of any kind of material the people could gather — plastic and tin sheeting, wood, cardboard, whatever. These were people who didn't have luxurious houses to begin with, but who had decent, cozy homes they were proud of nonetheless.

In the span of a few minutes, their homes were turned into either piles of debris or shaky structures that were uninhabitable.

Into the disaster zone

By the time we reached Pereira and Armenia (the two biggest cities in the earthquake area), it was already dark so it was hard to assess the damage. Yet when we went through Armenia, I could see more than enough to give me an idea of what the quake had done. Block after block was filled with shops and apartment buildings that were vacant and dark with walls and windows missing. More than an occasional building had turned into a pile of rubble. In the span of a few minutes, their homes were turned into either piles of debris or shaky structures that were uninhabitable.

We arrived in Cordoba (population about 5,000), where we were to stay, by 10:30 pm. The slogan *Cordoba, mas futuro que pasado* (more future than past) recently had been spray-painted on walls and in several other places at the entrance to the town.

Our group was there to take a general survey of the health status — a sort of health diagnosis — of the *veredas*, small

Homes like this one were destroyed, and thousands of people were left homeless when an earthquake that measured 6.0 on the Richter scale hit Colombia in January.

Editor's Note: David Ross, 38, is a fourth-year medical student at The University of Texas Health Science Center at San Antonio. He was in Colombia when a devastating earthquake occurred there in January and volunteered his services to the Red Cross to help disaster victims. This article, originally written as a letter to his family, is an account of some of his experiences.

rural communities outside Cordoba. We relieved a group of social workers who had run their own diagnosis of the social structure of the *veredas*, and we were to be relieved in 2 days by a group of engineering students who would inventory the structural damage to rural buildings and houses. We slept in sleeping bags on the floor in the Red Cross headquarters in Cordoba because it was one of the strongest structures in town and apparently had suffered only minor damage. Water service was only occasional, and electricity came and went as it pleased. We unloaded our stuff as the social workers loaded theirs for the trip back to Medellin.

We were greeted by the Red Cross medical coordinator and Andres Ospina, the Red Cross coordinator, who gave us the general low-down on living and eating arrangements. We also were told more about our job there, and we learned it would not be as demanding as we were first led to believe. They had painted a picture of us walking hours into the country, taking medical surveys, eating rice and beans, sleeping under coffee trees in the rain, and then making the long walk back the next day. However, the Red Cross volunteers had all made trips with the social workers before, and none had any problems returning that day in time for dinner at headquarters. We were served our first of many meals of canned *salchichas* (wieners), tuna fish, and sardines, and then we hit the sack.

We were awakened at 5:30 am by loud tropical music and the clang of dishes by someone washing dishes and preparing breakfast to the accompaniment of his jambox. By 6:30, everyone had made it down to the river to bathe because the city water service was not functioning yet. Plunging into the river was a pretty cold way to wake up, but I was getting used to cold baths there.

After a gut-filling breakfast of a warmed-up mix of Spam and who-knows-what-else, we divided into groups with a doctor or medical student, a Red Cross volunteer, and a local health promoter. These promoters are similar to home health nurses who go out into the *veredas* on a regular basis and check up on the people to manage their health needs. Because there were more students than *veredas* we doubled up some. At first, they were reluctant to send me out at all into the rural areas for fear of the guerrillas and they wanted to keep me in the local makeshift clinic. But I pled my case and I was allowed to go with another doctor to *veredas* that were closer to the main town and supposedly safer.

David Ross and fellow volunteers Carolina and "Dr Catalina" pose in front of Red Cross headquarters in Cordoba during earthquake relief efforts.

We were supplied with a ration of *salchichas*, beans, tuna, sardines, and water. We also were given some oral rehydration powder mixes for children with diarrhea, some feminine napkins for women, and a pat on the back. Our health promoter, Amanda, arrived with some help of her own — two other health promoters —and we went to the fire station in search of a ride. One of the local firefighters, along with his trusty firedog, Rocky, gave us a ride in his well-used, red Nissan 4WD firetruck/jeep. The firefighter and his dog took us as far as the *vereda's* elementary school, where we began our survey with three families sharing an improvised shack on school grounds.

We were warmly welcomed, probably in large part because the health promoter was known to the people, and our Red Cross volunteer, Carolina, had been to the same *vereda* a couple of days earlier with the social workers. The people welcomed us and almost everyone pulled up chairs for us and served black coffee or water sweetened with unrefined cane sugar. When we stopped for lunch at one *finca* (something like a farm or country house), they served us soft drinks and gave us rice to eat with our *salchichas* and tuna fish.

At each *finca,* we began by asking how many families lived there and how the adults and children were doing. We asked about diarrhea, respiratory infections, and skin conditions in the children because these are prevalent when sanitary conditions suffer and living conditions are crowded. We also asked the adults about chronic conditions they might suffer from, such as hypertension, diabetes, or cancer. I brought my blood pressure cuff and we monitored those with hypertension and found two people with extremely high blood pressure (greater than 210/110 mmHg). We were able to treat their conditions initially with an ACE inhibitor that the health promoter brought along. If we didn't have the medication we needed, we noted the name of the *finca*, the patient, and the prescription so that the health

promoter could take it by later when she made the rounds with the engineers.

At the first *finca,* we prescribed dicloxacillin for a man with an infected skin wound and Garamycin eye drops for a child with an eye infection and gave instructions to keep the child's hands washed so that he didn't stick dirty fingers into his eyes. One of the children also had diarrhea, so we left a few packets of the oral rehydration mixes with instructions on how to prepare it.

We went from *finca* to *finca* with our health promoter leading the way and introducing us as "Dr David" and "Dr Catalina" from the Cruz Roja.

The views along our walks between *fincas* were absolutely gorgeous from one mountain across to the other. Wherever you looked, you could see green mountains with fertile valleys in between. I enjoyed the walks between the *fincas* almost as much as the home visits. The countryside was so peaceful compared with the busy noise of Medellin, and the views were something to put on a postcard. Almost every house we visited had suffered some sort of damage because of the earthquake, some destroyed or uninhabitable. Yet most people had already come to grips with the situation. Many had not ventured into the cities and didn't know the extent of the damage. Many were afraid to go back into the houses for fear of being trapped during one of the frequent aftershocks. Several of the people we saw were suffering post-traumatic stress disorder (PTSD) with insomnia, fear of enclosed places, headaches, and nightmares. One young woman was suffering from PTSD and grief over the loss of her only child, who was 28 months old.

One family we saw was cleaning up the huge pile of rubble left when their house collapsed, but they seemed resigned to the loss. They told us they had just moved to the *finca* 4 months ago from Armenia, one of the hardest-hit cities.

In probably the strictest sense of the word, the people we saw were "poor." These people had few possessions and even fewer luxuries. They worked hard in the home or in the fields, yet they

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CHECK IT OUT!

TexasMedical Association

did not seem burdened with their lack of fortune. The homes they lived in, what was left of them, were modest. The ones I saw had electricity but none had phones; several had refrigerators and televisions. Most seemed to be constructed of either cinder blocks or *bajareque*, a common technique involving a frame made of *guadua* cane in which they pack mud and then cover it with stucco. When these collapsed — and they seemed to be susceptible to it — they left huge piles of cane and dried mud. None of the houses had air-conditioning; most of them just had open window frames, which the mild climate allows. Most of the people seemed to get their water from rainwater or by piping it in from one of the many streams and then boiling it. For cooking, people relied on wood-burning stoves. Catalina, the physician I was with, told me that many of the women suffered from chronic obstructive pulmonary disease, not from smoking tobacco but from the many years of working in kitchens and being around the wood smoke.

The first day we went out, we found many people with minor medical conditions that needed treatment. On the second day, we went to a smaller *vereda*, where almost everyone we met was in good health, so our day was much shorter and easier.

Back to Medellin

That night, a bus was to arrive with the engineers who would check the structural integrity of the rural buildings. We would return to Medellin on the same bus that night once they had unloaded. When they finally arrived at 11 pm, it had been raining hard for several hours. There was confusion when arriving and departing groups met at the door. We soon learned that the bus's windshield wipers weren't working and we would have to stay another night.

The Red Cross headquarters building already was crowded without the new group and now it was going to be even worse, especially because the toilets were not working and the water had shut down again. I was not looking forward to spending another night there but we had no choice. We organized our sleeping arrangements as best we could. Around midnight, when we had already gotten ready to go to sleep, we heard they had fixed the bus and we would leave immediately. We hurriedly said our good-byes and boarded the bus. When we arrived back in Medellin the following morning, I felt glad to be back and looked forward to a hot shower and a soft, warm bed.

Almost every house we visited had suffered some sort of damage because of the earthquake, some destroyed or uninhabitable.

I never imagined when I traveled to Colombia that I would be involved in an earthquake relief effort. I had mixed feelings about the whole event. It was a terribly tragic time for so many people, but for me it was a unique experience that allowed me to see the destruction that an earthquake can cause, participate in a small part of a disaster relief effort, discover an unknown part of Colombia, see the way many people live in the countryside, help in what small way I could, and, probably best of all, experience the hospitality and generosity of all the people we saw in the *veredas* of Cordoba. ★

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WEDNESDAY MAY 5

Sports Events
C. Lincoln Williston Golf Tournament

THURSDAY MAY 6

8-9:30 am
House of Delegates Opening Session

8 am-5 pm
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10 am-1:30 pm
Reference Committees

Scientific Sections
Digestive Diseases (9 am-noon)

Symposia
Emergency Medicine (9 am-1 pm)

2-5 pm
General Session (Underwritten by Texas Medical Liability Trust)

5-6 pm
Meet the Speakers Reception/Book Signing

After 6 pm
CMS Meet the Candidates Reception
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Alliance Dallas World Aquarium Dinner With Ross Perot

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Nightlife Shuttle

7:30 am-5:30 pm
Exhibits

9 am-noon; 1:30-4 pm
House of Delegates

9-10:30 am
Mercer Investment Seminar

NEW!

8 am-5 pm
Educational Tracks
The Business Aspects of Medical Practice
Ethics EPEC End-of-Life Care (7:30 am-5:30 pm) NEW!
Technological Advances in Medicine (2-5 pm)

8 am-5 pm
Sections
Endocrinology (8 am-12:10 am)
Family Practice (9 am-5 pm)
Neurological Surgery
Obstetrics and Gynecology (2-5 pm)
Ophthalmology
Otolaryngology (9 am-5 pm)
Plastic, Reconstructive and Maxillofacial Surgery
Psychiatry (9 am-5 pm)
Public Health (8 am-4:15 pm)
Surgery

8 am-5 pm
Symposia
Blood and Tissue Usage (2-5 pm)
Diabetes (2-5 pm)
Sports Medicine

8 am-5 pm
Specialty Societies
Texas Dermatological Society (2-5 pm)
Texas Orthopaedic Association

Noon-1:30 pm
TMA/TMAA Presidents' Installation Luncheon

2-3:30 pm
Mercer Investment Seminar

6-11 pm
TMA Foundation Benefit – New York Nights

After 6 pm
Alumni Events
Specialty Society Functions
Family Night Out Shuttle

SATURDAY MAY 8

Nightlife Shuttle

Sports Events
Tennis

7:30 am-4 pm
Exhibits

NEW!

8-9 am
General Session

8:30 am-2 pm
Heard Natural Science Museum and Wildlife Sanctuary

9 am-4 pm
Culture Bus Tour

9 am-5 pm
Educational Tracks
The Clinical Practice of Medicine (9 am-3:30 pm)
Computers in Medicine
Ethics EPEC End-of-Life Care (7 am-5:30 pm)
The Science of Alternative/Complementary Practices (9 am-3 pm)
Socioeconomics (8:30 am-5 pm)

9 am-5 pm
Specialty Societies
Texas Dermatological Society (8:30 am-noon)
Texas Orthopaedic Association
Texas Society of Anesthesiologists

9 am-5 pm
Scientific Sections
Allergy, Asthma and Clinical Immunology (7 am-5 pm)
Colon and Rectal Surgery (9 am-12:30 pm)
Neurological Surgery
Ophthalmology
Otolaryngology (8:30 am-noon)
Pediatrics (9 am-12 pm)
Physical Medicine and Rehabilitation

9 am-5 pm
Symposia
Adolescent Risk Assessment (9 am-noon)
Cancer: What Primary Care Physicians Need to Know
Diabetes (9 am-noon)
Heart Care Partnership (9 am-1 pm)
Pain (9 am-noon)
Sleep Disorders (8 am-noon)

House of Delegates Sections
Organized Medical Staff
Medical Student
Resident Physician
Young Physician

After 6 pm
Alumni Events
Specialty Society Functions

SUNDAY MAY 9

EPEC Train-the-Trainer Workshop (8 am-noon)
Texas Dermatological Society (8:30 am-noon)

TexMed'99 Educational Showcase & Expo

REGISTRATION FORM

May 6-9, 1999 ▪ Wyndham Anatole Hotel, Dallas

One form per person. Duplicate as needed.

1 Complete registration form following steps 1 through 11 and return by fax or mail with payments. Pick up tickets and badges at the registration area in the Atrium 1 lobby at the Wyndham Anatole.

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2 Registration Fees

MEMBERS (Please check the applicable box)

❑ Physician FREE ❑ Medical Student FREE ❑ Intern, Resident, Fellow FREE ❑ TMA Member's Family *(attach names)* FREE

NONMEMBERS

❑ Physician @ $200 ❑ Intern, Resident, Fellow @$10 ❑ Medical Student @$10 ❑ Allied Health Personnel @$10
❑ Approved Visitor @$50 ❑ Nonmember's family over age 21 (attach names) @$10 ❑ Speaker (waived)

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3 Educational Tracks

Please indicate which of the following educational tracks you plan to attend:

NEW!

❑ The Business Aspects of Medical Practice (Friday)
❑ Technology Subtrack #1: Technological Advances in Medicine (Friday)
❑ Ethics EPEC End of Life Care (Friday and Saturday)
❑ The Clinical Practice of Medicine (Saturday)
❑ The Science of Alternative/Complementary Practices (Saturday)
❑ Socioeconomics (Saturday)
❑ Technology Subtrack #2: Computers in Medicine (Saturday)
❑ EPEC Train-the-Trainer Workshop (Sunday, 8 am-noon)

Please indicate which specialty program you plan to attend _____

4 Installation Luncheon $

Friday, May 7, noon-1:30 pm, Chantilly Ballroom West @ $15 per person x____ =

5 FAMILY ACTIVITIES $

❑ Dallas World Aquarium Dinner with Ross Perot (Thursday) @ $ 65 per person x____ = $____
❑ Concurrent Dallas World Aquarium Children's Activities @ $ 15 per child = ____
❑ Culture Bus Tour (Saturday)
❑ Heard Natural Science Museum and Wildlife Sanctuary (Saturday) @ $10 per person x____ = $____

6 ON-SITE CHILD CARE Child care will be offered at the Wyndham Anatole for Thurs.-Sun. daytime functions. $

Thurs.-Sat., 7:30 am-5:30 pm: Daily rates-Children 6 weeks to 3 years (not toilet trained) $39 per child; 3 years and up (toilet trained) $29 per child. Half-day rate for Sunday: Children 6 weeks to 3 years $29 per child; children 3 years and up $20 per child.

7 SPORTS EVENTS $

❑ C. Lincoln Williston TMA Golf Tournament (Wednesday) @ $125 per person x____ = $____
❑ Tennis (Saturday) @ $25 per person x____ = $____

8 New York Nights - TMA Foundation Benefit $

Friday, May 7, 6-11 pm, Wyndham Anatole Dallas Hotel
Option 1: Regular Tickets $100 per ticket x____ = Regular Ticket total $_____
Option 2: NYC Sponsor $125 per ticket x____ = NYC Sponsor total $ _____

9 Advance Copy of Final Program with presentation summaries and complete details (available early April) @ $10 $

10 Medical Student/Resident Sponsorships $

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Above and beyond

Physicians demonstrate the meaning of 'putting patients first'

"For where there is love of man, there is also love of the art."

— Hippocrates

Cash flow. Staffing problems. Workers' compensation and malpractice laws. Piles of paperwork. With so many distracting details competing for their attention, physicians often must struggle to keep alive the ideals that compelled them to enter medical school.

But throughout Texas, many doctors robustly live those ideals every day. "Putting Patients First" isn't just a slogan for Kenneth E. Salyer, MD, who battles insurers for children with facial deformities; for Janet Gildea, MD, and Lisa Rouse, MD, who provide free or low-cost care to those in need; or for Oscar Fonseca, MD, who helped procure medical supplies for Central American hurricane victims. Their stories remind us that sometimes — as physicians and as humans — doing what's right means doing what's extraordinary.

By Sherri Deatherage Green

Putting Patients First

Kenneth E. Salyer, MD

While a resident at the University of Kansas, Dr Salyer treated a young woman whose face had been smashed in a traffic accident. The technology available in the 1960s was not sufficient to restore the patient to a normal appearance. For 2 years, Dr Salyer watched the woman struggle to overcome not only the physical but also the social and psychological consequences of her tragedy.

"I knew there had to be a better way," Dr Salyer said.

Years later, he observed a daylong procedure demonstrated by Paul Tessier, MD, the French pioneer of the craniofacial specialty. Excited by this breakthrough in reconstructive surgery, Dr Salyer dedicated his career to helping people with facial deformities lead normal lives. In 1970, he performed the first such operation in the Southwest. The founder and first professor of the Division of Plastic Surgery at The University of Texas Southwestern Medical School, Dr Salyer continues to research and teach craniofacial techniques. He serves as a clinical professor at The University of Texas Health Science Center in San Antonio and as an adjunct professor of the Baylor College of Dentistry.

Most of the patients treated in Dallas' International Craniofacial Institute are children born with birth defects such as cleft lips and palates, syndromic and simple craniosynostosis, and other disfiguring conditions. Dr Salyer founded the institute in 1986 and also treats conditions that result from trauma, tumors, and disease.

"It's a surgery of self-esteem," Dr Salyer said. The institute's motto is "Reconstruct a face, create a new life." He treats many children when they are so young they never remember the surgery. "We try to work on them before they go to school. That's when the kids start making fun of them."

But craniofacial surgery does more than improve a patient's looks. In many cases, facial injuries or birth defects can hinder breathing, hearing, speech, or other vital functions. Yet increasingly, insurance companies deny coverage for such procedures, claiming they are merely cosmetic. The American Medical Association defines cosmetic surgery as reshaping normal body structures to improve appearance and self-esteem. Reconstructive surgery involves procedures to correct abnormal body structures.

One look at before-and-after photos of Dr Salyer's patients reveals the weakness of the managed care argument. "Even 5 years ago, this problem didn't exist at all," Dr Salyer said. "Managed care has been a major roadblock."

To help patients overcome those roadblocks, Dr Salyer founded the World Craniofacial Foundation. It has provided education, transportation, and housing, and donated medical care to families all across the United States and from 60 countries. The foundation survives on financial donations and on services volunteered by about 50 Dallas-area doctors. A quarter of Dr Salyer's patients receive some type of assistance from the foundation.

Dr Salyer also is involved with the Coalition for Insurance Coverage of Children's Deformities and is featured in a video the organization uses to raise awareness of the problem. So far, 14 states have passed statutes requiring health insurance policies to cover at least some types of birth defects and deformities. State Sen John J. Carona (R-Dallas) has sponsored Senate Bill 161 to create such a law in Texas. In Congress, Rep Sue W. Kelly (R-NY) has introduced House Bill 49, the Treatment of Children's Deformities Act.

In addition, Dr Salyer has worked to raise awareness of craniofacial surgery by appearing on national and international television programs, coauthoring seven books, and being featured in *Parade* magazine.

"I think most doctors don't have a problem putting patients first," Dr Salyer said. "We're humanitarians. The

"I think most doctors don't have a problem putting patients first."

Kenneth Salyer, MD, founded the International Craniofacial Institute in Dallas and helps people with facial deformities lead normal lives.

interference has mainly come about as a result of managed care. It's making it more and more difficult to put patients first because [doctors] are so caught up in the business aspects of medicine."

Lisa Rouse, MD

Visit the Raphael Community Free Clinic in Kerrville on any given Thursday night and you probably will find Dr Rouse treating uninsured or underinsured obstetrics patients.

The year-old clinic is named after the Archangel Raphael, whose name translates as "God heals," explains Sister Marge Novak. A Franciscan nun and nurse practitioner, Sister Novak met Dr Rouse when the two worked together at a local medical practice. When the sister decided to start a free clinic, Dr Rouse became one of her most enthusiastic supporters and helpers.

"I just wanted to do something in our church to help people who couldn't get to the doctor," Sister Novak recalled.

The community quickly jumped on Sister Novak's bandwagon. A local businessman built a new facility for the clinic.

Volunteer doctors staff the clinic on Thursday nights, and Sister Novak sees patients an additional 3½ days a week. Local restaurants feed the physicians and lay volunteers who staff the office. Medicines are donated, while Sid Peterson Memorial Hospital and an Austin laboratory help provide x-rays and lab work. Funding comes from grants and private donations, and the community dedicated last year's charity ball to the clinic.

"I've seen a lot of free clinics, but I've never seen one with these types of services and these hours available. There's a much wider range of what we can do than just trying to put a Band-Aid on it," Dr Rouse said. "I think there's this kind of need in any community."

Dr Rouse has delivered 15 or 20 babies in the last 6 months for women she has treated at the clinic. Since it opened, almost no expectant mothers have shown up to deliver at the local emergency room without prenatal care.

Practically all of the women Dr Rouse treats at the clinic are uninsured or underinsured. Many of the clinic's patients are undocumented aliens from Mexico, but a significant number are working people who don't have insurance or who have high deductibles.

Dr Rouse worked for 2 years in Alaska and another 2 in Arlington. She moved to Kerrville so that she could provide a full range of medical services "like the old GPs did." She doesn't toot her own horn much, but Sister Novak is quick to sing the praises of the physician who was given the 1998 Healthcare Leadership Award by the Kerrville Chamber of Commerce. Eight physicians rotate Thursday-night duty at the free clinic, but Dr Rouse is there practically every week and always is willing to help out over the phone when needed. "It's a service for her, not a business," Sister Novak said.

"There's a big gap in the availability of health care to a certain population. I believe that if you have the capability of helping people, you should give something back," said Dr Rouse, who started a solo practice last year. "I consider my patients to be part of my family."

Janet Gildea, MD

Ministering to the health care needs of poor patients in southeast El Paso County is part of a larger calling for Dr Gildea. In addition to being a family physician, she is a nun of the Cincinnati-based Sisters of Charity order.

"I found out during college that there were such things as sister physicians," she said. "I didn't realize that you could be both a sister and a doctor."

For the last 4 years, Dr Gildea, along with two other sisters and a small staff, has operated a primary care clinic that is open 5 days a week for residents of nine desert *colonias*. Only three of the communities have running water.

The sisters have chosen to keep La Clinica Guadalupana small and its processes simple so that it is accessible to

"I believe that if you have the capability of helping people, you should give something back. I consider my patients to be part of my family."

Lisa Rouse, MD, talks to a patient at the Raphael Community Free Clinic in Kerrville.

Janet Gildea, MD, examines a child at La Clinica Guadalupana in El Paso.

patients. Funding comes from grants, private donations, and what little money the patients are able to pay. Costs are kept relatively low, in part because the sisters receive only stipends and not professional salaries. The Texas Tech University Health Sciences Center in El Paso helps out by sending its mammogram van once a month and by delivering babies born to the clinic's obstetric patients.

clinic also offers educational materials in Spanish, teaches CPR classes in the remote *colonias*, and has established a walking program for patients with diabetes and hypertension.

Dr Gildea also makes what she terms "*colonia* calls." The area lacks public transportation, and some residents would not visit the clinic because they have no money or they fear being turned

"Family practice belongs out in the community, and that's where we are."

"Virtually no one in our patient population has private, third-party insurance," Dr Gildea said, "but everyone is seen, regardless of ability to pay." Most are women and children. The area's unemployment rate is very high, and although most heads of households work, they generally labor in low-paying or part-time jobs.

Dr Gildea is the former chair of TMA's Preventive Medicine Task Force, and much of the clinic's efforts are focused toward prevention. Pap smears, breast examinations, immunizations, prenatal care, and diabetes and tuberculosis screening are provided regardless of the patient's ability to pay. The

in to immigration officials. So every Tuesday afternoon, Dr Gildea and her staff set up in a house or office in one of the *colonias* to treat patients, perform checkups, and provide immunizations.

"Family practice belongs out in the community, and that's where we are," Dr Gildea said. "Sisters have always gone out to where the needs are, often in places where other people didn't want to go."

Oscar Fonseca, MD

"I'm just a regular guy, nothing special," insists Dr Fonseca, a Houston physician who specializes in internal medicine and endocrinology.

Although modest about his own accomplishments, Dr Fonseca is proud of the work being done by the Hispanic American Medical Association of Houston (HAMAH). In its 9 years of existence, the organization has given its members a voice in national policymaking societies on issues that affect them and the Hispanic community. Dr Fonseca has held several offices and served last year as the group's president.

During his year as HAMAH president, Hurricane Mitch devastated parts of his native Honduras. Although Dr Fonseca downplays his own role in the relief effort, he helped coordinate the donation of medical supplies the organization sent to Honduras.

"Our profession is a profession of help to people having difficulties with health problems," he said. "This was a very clear situation in which there was a health problem in the areas affected."

One of Dr Fonseca's loves is teaching. He worked as a professor of medicine for 3 years at his alma mater, the University of El Salvador. Now, he is a clinical professor at The University of Texas-Houston Medical School and teaches a course on physical diagnosis each year as a volunteer. Dr Fonseca's chief goal during his year as HAMAH president was to provide Category I continuing medical education (CME) credit for its scientific programs. HAMAH accomplished that goal, and now members will receive 6 hours of CME credit for the price of the annual membership. Dr Fonseca also helped organize a local health fair in association with the Knights of Columbus. In addition, HAMAH provides five scholarships a year to students from local medical schools to provide stipends for internship interviews.

Like their colleagues throughout Texas, Drs Salyer, Rouse, Gildea, and Fonseca demonstrate on a daily basis what it means to put their patients first. ★

Sherri Deatherage Green is a freelance writer in Farmers Branch.

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Injuries at school: a review

SAMIR M. HAQ
M.M. HAQ, MD

Injuries are the leading cause of morbidity and mortality in children older than 1 year, with a significant proportion occurring in the school. This article reviews the past 10 years of literature on school-related injuries. The incidence, types, anatomic locations, sites, and activities related to injuries on school premises are presented. Comprehensive studies in a population where injuries occur in a supervised environment are needed. The role that cooperative programs involving schools, parents, and other agencies can play in developing school safety policies is discussed. Because injuries are common in the daily lives of thousands of school children, a proactive attitude coupled with intensive research on the causes, prevention, and better on-site management would impact immensely on the health status of school-going Texans.

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INTRODUCTION

The National Center for Health Statistics reported in 1987 that unintentional injuries were the leading cause of mortality and morbidity among school-aged children (1). A recent study estimated that 3.7 million children suffer a substantial injury at school every year (2). The National Academy of Sciences has called injuries a major underrecognized public health problem (3). Injuries at school are a cause for concern because they occur in a supervised environment and, thus, could be potentially preventable (4). The cost of treating these injuries is estimated at $3.2 billion per year (2). The number of studies evaluating school-related injuries is limited. This article reviews the published literature on the subject and discusses strategies for decreasing the mortality and morbidity attributable to school injuries.

MATERIALS AND METHOD

A MEDLINE search of the articles published in the English language on school-related injuries for the past 10 years was performed. Articles were reviewed along with selected references from them.

RESULTS

The results of various studies including 5 large-scale studies of injuries at school were remarkably similar (Table).

Incidence

The overall rate of injuries reported has ranged from 1.6 to 9.22 per 100 students per academic year (5,6). Retrospective studies in general have reported lower incidence than have prospective studies, probably related to lack of careful monitoring of the data, underreporting, and differences in definition and classification of injuries (6,7). Males consistently had an approximately 1.5 times higher risk than females in all the reported studies (8). The middle school years (grades 6 through 8) had the highest incidence, which was thought to be related to increased activity level, participation in sports, and puberty-related years, termed "the clumsy age" (9). High school students had the lowest incidence (10). The Texas Department of Health does not have accurate data on the incidence of injuries at school.

Risks related to variables such as month, day, and time of injury have not been analyzed consistently. However, 2 studies noted a seasonal variation with increased incidence in the first 2 months of school (5,6). This finding was thought to be secondary to the excitement of returning to school after summer recess and to football practices in autumn. The risk was lowest in the months from February though June. The Boulder Valley school injury study reported that 41% of all the injuries occurred in the morning session, and fewer injuries were reported after school hours in spite of high participation in organized and unorganized sports activities (6).

Types of injuries

Cuts, abrasions, and contusions were the most frequently reported injuries. Contusions became more frequent with advancing grades (6). High school students were more likely to have sprains and dislocations than any other types of injuries, probably related to sports and athletics. Fractures, though uncommon with an incidence of 0.27 to 1.29 per 100 students per year, were the most frequent of serious injuries (6,7). Fractures were more common in grades 7 through 9, and among males (11). Upper extremity was the most common site of fractures. A Seattle public school review showed the following frequency of the more commonly seen fractures: fingers, 22%; wrist, 16%; and arm, 15% (11). In general, boys had higher

rates for all types of injuries than did girls, except for elementary level girls who sustained fractures 3 times more often than boys (6).

Anatomic distribution of injuries
Extremities (41.3%) are the most common site, followed by head injuries (39.2 %) (12). However, head and facial injuries are the most common injuries in elementary school children (7), and upper extremity injuries are the most common in the secondary school age group. Injuries to the neck, back, spine, chest, abdomen, and pelvis occurred with comparable frequency in both groups. Multiple injuries were rare. Girls had a higher incidence of injuries to the torso, feet, and eyes compared with boys at the elementary level. Two percent of the injuries involved the spinal cord and resulted mostly from sports (12).

Site of injury
In general, playgrounds exceeded all other sites of injury for all age groups (1.09 per 100). Activity on the playground accounted for 3 times as many injuries as any other site among elementary school students (6), while the gymnasium was the next common location. Middle school students were more likely to be injured on the athletic field or in the gymnasium. Equipment such as climbing bars was associated with 38% of the injuries occurring on the playground (6). One quarter of the playground injuries were classified as severe. Kindergarten students had the lowest incidence at 3 per 10,000 students each year (13). First-grade students had the highest incidence at 19 per 10,000 (13). The role of playground surface in the incidence and severity of injury has been studied (13). At 7.1 per 10,000 student-years, sand has the lowest incidence (13). The injury rate for asphalt was almost 6 times greater than that of sand (13). Mats, gravel, and grass had incidences ranging from 12.4 to 15.8 per 10,000 student-years (13).

School injuries.

Incidence	1.6-9.22 per 100 students annually
Male:female occurrence ratio	1.5:1
Anatomic distribution, %	
Head and neck	29-64
Upper extremities	17-25
Lower extremities	14-18
Eyes	7-8
Torso	3-7
Dental	3
Type of injury, %	
Playground	59
Falls	32-77
Athletics and gymnastics	9-22
Time of day, %	
Morning	41
Lunch	27
Afternoon	16
Month of injury	Highest — first 2 months of school Lowest — February through June
Injury occurrence by grade, %	
Junior high school	40-50
Elementary school	30-40
High school	15-20

Data summarized from references 6, 7, and 18.

Risk of injury by grade level
Children aged 10 to 14 years were more prone to injuries than were other age groups (12). Targeting this group for intensive injury-prevention strategies could be most cost-effective.

Types of activities related to injury
Organized sports, athletics, and unorganized sports are the most frequent injury-causing activities. Seventy percent of the playground accidents result from falls (14). Injuries from falls are among the most serious, accounting for approximately 75% of playground-related deaths (15). Falls led also to the highest rate of emergency room visits and hospitalization (16). Swings have been associated with a disproportionate number of head injuries (17). Striking mechanical or other objects was another cause of injury (18).

Recurrent injuries
A small number of school children sustain a disproportionate share of injuries (19). These children have been called "injury-prone children." However, some authors have questioned the idea of an "injury-prone child" (20). The proportion of recurrently injured children is small. Most of them sustained only 2 injuries, and most of the injuries were clustered within a short time (19). Recurrent injuries are more common among junior high school boys engaged in athletic activity (9) and in children attending alternate school programs with prolonged hours (10).

Causes of injury

Children are inherently at an increased risk for injury because of their limited perceptions and inexperience. They are often absorbed in themselves and, therefore, oblivious to their surroundings. Besides sports and athletics, aggressive behavior has been cited as a cause of injury by Johnson and Carter (21). They found that 13% of all accidents were caused by aggressive behavior such as fighting, pushing, and throwing objects. The Boulder Valley school study reported that 41 of the 501 injuries recorded were related to fighting, with the highest rate of aggression-related injuries occurring in grades 7 to 9 and in males with a ratio of 4.7:1 (6). Angle found increased risk of injury in children with deficient locomotor skills such as balancing and coordination in the group aged 6 to 9 years (22). Children with preexisting musculoskeletal disorders have higher morbidity with trauma; therefore, recognizing these conditions is important for prevention and optimal treatment (23).

Weapons-related injury

Violent deaths in school are more common than previously estimated (24). Firearms are responsible for a majority (77.1%) of them (24). According to the US Department of Justice, 135,000 students carry guns to school each year (25). Gun carrying has been on the increase in Texas schools, and we can anticipate increasing numbers of gunshot wounds (25). Significant predictors of gun carrying include male gender, not living with both parents, drinking alcohol heavily, participating in fights, damaging school property, and perceiving that at least a few other students brought weapons to school (26). Most shootings were intentional (65%), with drug or gang-related activity being the most common reason given (24). The Texas Department of Health does not have any specific data on gunshot injuries at school. Weapons-related injuries cannot be viewed in isolation from other behavioral problems. Interventions should target not just individuals but the larger school and community contexts in which this behavior occurs.

DISCUSSION AND CONCLUSION

The National Academy of Sciences concluded in 1988 that injuries are a major unrecognized health problem. In spite of its significance, this subject has received insufficient attention. Only about half a dozen studies have evaluated the epidemiology of school injuries. Five large-scale studies reveal rather similar findings. The annual overall injury rate varied from 1.6 to 9.22 per 100 students. Males sustained 1.5 times more injuries than did females. Elementary school students were more frequently injured in the playground, while middle/junior high students were injured on the athletic field and high school students in the gymnasium. On the playground, climbing bars accounted for 38% of the injuries.

The injury-reporting system is not uniform. A comprehensive and complete data-reporting form needs to be developed. Clear and standardized definitions for various injuries and a computerized reporting system across the state and perhaps the country would be helpful. The various professional organizations dealing with school health such as the American School Health Association, the American Academy of Pediatrics, and the National Association of School Nurses could develop guidelines and pathways that could be followed uniformly. Strict adherence to reporting would, of course, be needed since a previous study pointed out that 75% of injuries were not reported (27).

Research in the field of prevention is needed. Langley et al, reviewing data from a school district in New Zealand, thought that preventing falls from playground equipment offered one of the best potential preventions (28). Climbing bars have been recognized as a frequent cause of injury, but little work has been done to devise safer climbing bars. Uniform impact-absorbing surface needs to be developed under the climbing bars because it has been shown to decrease the injury rate (13). Other dynamic variables associated with injury-prone activities need to be studied, such as control of student behavior and interaction with schoolmates. A Swedish study reported that unsatisfactory schoolmate relationships were an important determinant of risk of injury at school (29). The proper ratio of adult supervisors to the number of children at play with various activities needs to be established. A policy for playground safety and in-service workshops by the school nurse for mentors and students could be developed and implemented on the model proposed by Utah State University (14).

The need for vigilance, research, and development of safer methodologies is evident from the fact that 88% of the injuries occur while students are being supervised (30). Clearly, the middle school grades need extra attention. A proactive program involving state and local government agencies in cooperation with community groups, schools, parents, and local hospitals following the model of the Harlem hospital injury prevention program could be adopted in other parts of the country, especially in urban areas (31). This program decreased hospital emergency visits by 12% as a result of an intervention that involved various community agencies in improving the safety of the playground.

Other programs, like the one at John Radcliff Hospital in Oxford, UK, could be explored on a pilot basis in the United States (32). This program established an injury-minimization team consisting of a trauma consultant, a liaison health visitor, 2 emergency room nurses, and a primary school teacher. They developed

pamphlets and other educational materials regarding safety skills for road safety, home safety, sports and leisure safety, and resuscitation science. The program incorporated age-appropriate activities such as poster board drawings, essay writing competitions, and viewing injury-minimization videos.

Feldman reported that on-site first aid was administered most often by teachers (9). He noted further that trained personnel were seldom present during playground activities and athletic events, and he proposed that all adults involved in scholastic athletics and playground supervisors be trained in first aid. School nurses in Texas do not undergo a standard injury-minimization course. The state health department should develop and mandate such a course, and it should provide appropriate audiovisual tools for injury-minimization programs. An injury-minimization team, headed by the school nurse, should exist at every school; its activities should include overseeing playground equipment safety. Periodic inspections of the playground equipment and evaluation of the playground surface should be mandated. Clear and consistent rules of behavior around playground equipment need to be posted and followed. A system of discipline for negative behavior should be implemented. The playground monitors should receive regular in-service training in injury minimization.

Methodologies for communicating with parents need to be evaluated and improved. School personnel must be well informed regarding the legal responsibilities for the standard of care, breach of duty, and other aspects of tort law (33).

Because school injuries are common in the daily lives of thousands of school children, a proactive attitude with intensive research on the causes, prevention, and better on-site management would impact immensely on the health status of school-going Texans.

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Winning the Stanley Cup Final Series is related to incurring fewer penalties for violent behavior

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Catastrophic and disabling injuries are being reported more frequently in ice hockey. Within the science of injury prevention, all possible avenues are being explored to address this devastating problem, especially in the areas of protective equipment, playing rules, teaching techniques, and awareness programs. Ice hockey injuries are in many cases caused by violent player behavior, which may be supported by coaches who believe that such behavior contributes to winning. To determine whether a relationship existed between violent player behavior and game outcome, 1462 recorded penalties from all 18 Stanley Cup Final Series from 1980 through 1997 were analyzed with a 2 x 2 chi-square analysis. A statistically significant association (chi-square = 7.111, P = *.008) was found between violent player behavior and series outcome, with the team drawing fewer violent penalty minutes being the winner of 13 of the 18 series. A period-by-period analysis of violent penalties incurred by the losing teams revealed a statistically significant difference between the first and third periods, with losing teams demonstrating more violent player behavior in the first period than in the third period. The results suggest that violent player behavior may be counterproductive to a favorable game outcome. Coaches at the highest level of competition may wish to adjust their team policies and recruiting practices to benefit from the plausible strategic advantage of reducing violent player behavior.*

This research was presented at the 1998 Ice Hockey World Championship International Symposium on Medicine and Science in Ice Hockey in Zurich, Switzerland, on Saturday, May 9, 1998, and published in the symposium's supplement, "Safety in Ice Hockey IIHF 1998."

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INTRODUCTION

Catastrophic and disabling injuries are being reported more frequently in ice hockey (1,2). Many players have suffered career-ending concussions and even permanent paralysis from irreversible injury to the brain and spinal cord (3,4). With the growing popularity of ice hockey, this tragic trend will continue unless the fundamental cause of the problem is found and corrected. No effective treatment exists for neurological damage to the brain and spinal cord. Prevention is the key, and it is becoming increasingly clear that coaches may hold that key (5,6). Ice hockey injuries are in many cases caused by violent player behavior, which may be supported by coaches who believe that such behavior contributes to winning (7–10).

Within the science of injury prevention, all possible avenues are being explored to address the devastating problem of catastrophic and disabling injuries in ice hockey, especially in the areas of protective equipment, playing rules, teaching techniques, and awareness programs (11). Without question, the scientific advances and technological improvements have merit. However, when the puck is dropped, the coach has the decisive influence over the player; the coach is the final arbiter of behavior on the ice; and the coach can also play an important role in injury prevention (12,13). Coaching attitude powerfully influences player behavior, which, in turn, affects directly the rate and severity of injury (14,15). Coaching expectations define the limits of appropriate player conduct during games and effectively establish the threshold for injury, as most injuries occur during games (16,17).

Many coaches, even at the highest levels, still allow inappropriate player conduct during games, not realizing that this undisciplined behavior can cause catastrophic injury (12,13,6). A 20-year Canadian study of spinal injuries in ice hockey players demonstrated that 30% of cervical injuries resulted from illegal checking from behind (12,6). Despite the clearly defined relationship between undisciplined behavior and catastrophic and disabling injury in hockey, many coaches still tolerate or even covertly encourage violent behavior for a very simple reason: they believe it to be essential to winning games (18,19,10,13). In the words of James A. Michener, ". . . the lure of fielding a winning team is so great, and the rewards to any coaching staff so attractive, that outright cheating is condoned. A coach . . . gains long-lasting accolades for having produced a winner. And if such coaches are building character, I must not understand the meaning of that word" (20).

Is the use of violence an effective coaching strategy for ice hockey as it is currently played? Do teams penalized for violent behavior experience greater success than teams who display less violent behavior? Previously published research (21,22,18,19,23–30) has not provided a consistent answer to these questions for 2 reasons: first, failure to sample a sufficient number of games over a considerable span of time, and second, failure to break down the aggregate statistic "total penalty minutes" to permit a more specific, detailed analysis of violent player behavior with the potential for injury. In an attempt to correct both of these shortcomings, we analyzed the 18 Stanley Cup Final Series from 1980 through 1997 (31) to determine whether a relationship existed between the frequency of penalties for violent player behavior and game outcome.

MATERIALS AND METHODS

This consecutive 18-year archival study focused only on the Final Series of the Stanley Cup for the seasons 1979–1980 through 1996–1997, consisting of a total of 90 Stanley Cup Final Series games.

Using official National Hockey League rule definitions (32) and previously published guidelines for the delineation of aggressive and nonaggressive infractions (33,34,26,28), we identified 18 violent player behaviors: attempt to injure, boarding, butt-ending, charging, checking from behind, cross-checking, deliberate injury, elbowing, fighting, goaltender interference, instigating, head-butting, high-sticking, kneeing, kicking, roughing, slashing, and spearing. A tally was made of each officially recorded episode of violent player behavior, without regard for the actual length of time of the penalty or combined penalties given for each infraction. Penalties for behavior without significant potential for injury, such as delay of game, holding, hooking, interference, too many men on the ice, tripping, and unsportsmanlike conduct were not included in the tally.

For each series, the number of officially recorded episodes of violent player behavior was determined across games for each of the 2 participating teams. Based on the outcome of the series and the number of officially recorded episodes of violent player behavior across the series, each team was categorized to either "won series" or "lost series," and to either "more violence" or "less violence." Although the results represent the entire population of Stanley Cup Final games between 1980 and 1997, a 2 x 2 chi-square test (less violence versus more violence; series won versus series lost) was used to evaluate the statistical significance of the categorization (α = 0.01), and Cramer's phi was calculated to quantify the strength of the association (35).

Violent penalties for the losing teams were further analyzed by time of occurrence to consider whether more violent player behavior took place in the first period or the third period. A paired *t* test was used to evaluate the statistical significance of the difference (α =0.05).

Table 1. Frequency of violence and series outcome.

	Won Series	Lost Series
Less violence	13	5
More violence	5	13

Violent penalties for the winning teams were further analyzed by period to compare the number of shots on goal during periods that had more violent penalties with the number of shots on goal during periods that had fewer violent penalties. The shots-on-goal differential was used as a performance measure and was corrected to reflect the effect of the frequency of violent player behavior during each period. The following formula

$$pc = \frac{p}{t - (n1 - n2)} \times 20$$

was used to control for the possible influence of nonviolent penalties on team performance, where pc = corrected performance measure, p = performance measure, t = total minutes playing time, n1 = total nonviolent penalty minutes given, and n2 = total nonviolent penalty minutes not served because of early penalty termination due to a power play goal. A paired *t* test was used to evaluate the statistical significance of the difference in performance (α =0.01).

RESULTS

As indicated in Table 1, the team with fewer episodes of violent player behavior was the winner of 13 (72.2%) of the 18 Stanley Cup Final Series contested from 1979–1980 through 1996–1997. The chi-square value of 7.111 indicates that the observed difference in series outcome was statistically significant (P = .008). Cramer's phi value was computed as 0.444, indicating a moderately strong relationship between the frequency of violent penalties and series outcomes.

Fig 1. Losing team violence during first and third periods.

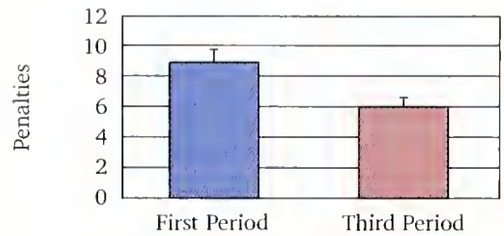
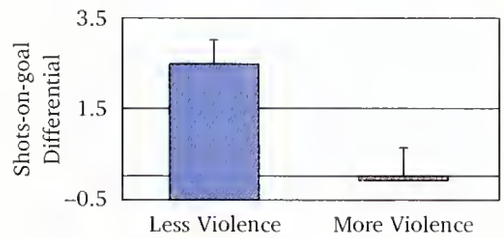


Fig 2. Winning team performance during periods played with less and more violence.



Losing teams were called for more episodes of violent player behavior in the first period than in the third period (Fig 1). Losing teams averaged 8.9 violent episodes in the first period compared with 6.1 violent episodes in the third period. The difference in violent penalties was statistically significant (t_{17} = 2.33, P = 0.032).

Winning teams produced more shots on goal during periods with fewer violent penalties (Fig 2). During periods with fewer episodes of violent player behavior, winning teams generated an average shots-on-goal differential of +2.5. During periods with more episodes of violent player behavior, winning teams generated an average shots-on-goal differential of 0.07. The difference in performance was statistically significant (t_{16} = 3.01, P = .008).

DISCUSSION

The analysis of the data suggests an evolution in the North American game of professional ice hockey at the championship level over the past 2 decades. The team with fewer episodes of violent

player behavior was the winner of 13 (72.2%) of the 18 Stanley Cup Final Series contested from 1979–1980 through 1996–1997. The results are even more dramatic since 1987–1988. In 9 of the last 10 seasons, the team with fewer episodes of violent player behavior has won the Stanley Cup. The winners of the 8 series before 1987–1988 were evenly split between the team drawing fewer and the team drawing more violent penalties.

Attributing victory in the Stanley Cup Final Series to drawing more or fewer violent penalties is, of course, an oversimplification. Reducing the number of violent penalties incurred will not, in itself, guarantee victory. A statistically significant association between more episodes of violent player behavior and losing the Stanley Cup does not, by itself, imply causality and must be interpreted with caution. Officially recorded episodes of violent player behavior may only represent a marker for yet another variable affecting both violent player behavior and game outcome. For example, when a player who is intent on violence steps on the ice, that same player may lose full capacity to anticipate the play, to break open for a pass, to support a teammate, or to immediately read and react to a turnover by assuming a defensive position. That player may not be able to perform as effectively as a team player while distracted by thoughts of revenge, retaliation, or intentional injury (36,24). The number of officially recorded episodes of violent behavior measured in this study may only represent a partial reflection of a much less visible and yet possibly far more pervasive underlying cognitive orientation towards violence, which may impact a player's ability to focus throughout the period, whether or not an official penalty is called. Negative player attitudes in response to adversity have been found to be predictive of disappointing athletic performance, both at the individual and team levels (37,38).

The strength of the association between the frequency of violent penalties and Stanley Cup Final Series outcomes over the past 18 seasons, especially over the last decade, makes it interesting to contemplate possible explanations for the observed relationship. That more violent penalties are incurred during the first period compared with the third period suggests that the violent penalties are not a reflection of frustrated behavior that might stem from falling behind in the game. Instead, incurring penalties for violent behavior early in the game may reduce the effectiveness of the proposed game plan by disrupting line changes, causing earlier fatigue, and providing an opportunity for the opponent to take more shots on goal. Winning teams averaged 2.55 more shots on goal per period when demonstrating fewer episodes of violent player behavior. This amounts to an average of 7.65 more shots on goal per game, and over the course of a 7-game series, would provide an additional 53.5 more shots on goal to teams playing with fewer episodes of violent player behavior. The potential practical significance of this association may be of some interest to coaches, although it must be interpreted with caution, as this association, although statistically significant, does not, by itself, imply causality (39). The moderately strong relationship between more episodes of violent player behavior and decreased team productivity, as measured by a decrease in the number of shots on goal per period, may actually reflect nothing more than the detrimental effects of excessive physiological arousal. Low-to-moderate levels of stress may facilitate athletic achievement to a point; at some point, the excessive physiological arousal accompanying violent player behavior may become counterproductive and interfere with achievement because as emotional intensity continues to increase, athletic performance may actually begin to decrease (40,41,36,42–44).

Simply counting the number of officially recorded episodes of violent player behavior does not differentiate between the hostile use of force and the legitimate use of force for self-defense. Further research that enables a distinction to be made between the use of force in a punitive capacity and the use of force in a self-defensive capacity may lead to the development of effective training for hockey players in the measured, controlled, and appropriate use of force. Such training in the proper use of force has been found effective in enhancing the performance of law enforcement personnel (45).

A team that incurs penalties more frequently for violent player behavior is a team that is not playing effectively and, as shown by the results of this analysis of 18 years of the Stanley Cup Final Series, a team that is more likely to lose. Rule changes in recent years along with the growth in the number of European "finesse" players in the National Hockey League may have eliminated any advantage that coaches might perceive as a strategic benefit of playing a violent game (46,47). Former Toronto Maple Leaf owner Conn Smythe's infamous adage may indeed be outdated and no longer applicable to the game of ice hockey at the highest level of competition in North America: just because you can beat them in the alley may not mean you can beat them on the ice.

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COMMENTARY

Professional ice hockey and violence in American society

BY HOWARD A. MOORE, MD

Too many people, professional ice hockey is the model of institutionalized violence. As the old saying goes, "Fans go to watch a fight and a hockey game breaks out." McCaw and Walker (pp 66-69) have attempted to elucidate the relationship of the incidence of violence in 18 consecutive Stanley Cup Final Series matches relative to the outcome of those matches. They have concluded that the winning team drew fewer violent penalty minutes in 13 of the 18 matches, and the losing team committed one-third more violent acts in the first period than the third. They relate this finding to the strategy of the opposing coaches and deem the condoning of violence counterproductive when victory is the goal. The authors are to be congratulated for their careful analysis and the elucidation of the obvious lesson for coaches and players — violence for the sake of violence does not win championships.

When considering the impact of violence in sports on the public and on youth, in particular, violence in our society as a whole must be addressed. Our society is a violent society. It is no longer possible for the average citizen to discount the likelihood of being confronted with violent behavior such as gang drive-by shootings, carjackings, rape, and schoolyard shootings. Our prisons are overflowing with youthful offenders.

Sociologists tend to explain the phenomena of increased, capricious violence in society, as a whole, by pointing to the disappearance of the nuclear and extended family influence, the rise of the drug trade, and the persistence of poverty with its tendency to breed disaffection in youth. Violence is a constant in the Darwinian "survival of the fittest" world. We, as humans, would prefer to think that we have risen above this plane. The continuing presence of violence in our daily lives and particularly in our sports and entertainment betrays the truth.

Many sporting events, such as professional ice hockey, boxing, football, rodeo, and auto racing, are violent by nature. The popularity of these sports bespeaks our desire to experience violence vicariously. The media, in response to public demand, increases our opportunity to view violence by promoting and televising pseudo-sporting events such as professional wrestling, Roller Derby, the Jerry Springer Show, etc.

According to the American Psychiatric Association (APA), in the 1996 National Television Violence Study, by age 18, the typical American child has seen 16,000 simulated murders and 200,000 acts of violence while watching 28 hours of television per week. The perpetrators of the violence went unsanctioned in 73% of these violent scenes. The study concluded that the most effective means of preventing imitation is to show punishment for such acts. Failure to do so desensitizes the viewer and promotes identification with the aggressor.

With this background of saturation exposure to violence in our media, entertainment, and sports, it is fortunate, I must say, that in my sports medicine practice, I have not been able to identify any significant increase in injuries associated with high school or amateur athletes emulating violence seen in the media or on the sporting field. I am reassured that the study results of McCaw and Walker reinforce the recommendations of the APA study, that, in effect, the best way to prevent imitation of violence is to show that violence does not necessarily reward the individual or team committing the violence. The lesson that the practitioner may glean from these results is that education of our friends, family, and patients is the most efficacious means of preventing future violent behavior. Again, violence committed as part of a game strategy or in life, in general, does not make one a winner.

Dr Moore is an orthopedic surgeon with the Sports Medicine Clinic in Dallas and was chair of the TMA Committee on Sports Medicine.

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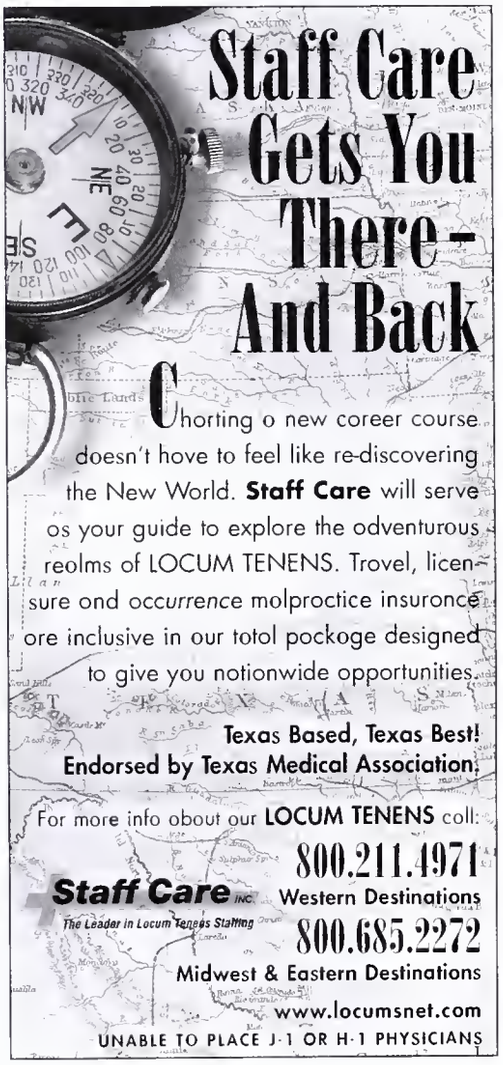

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Endovaginal	April 23-24

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Current Topics in General Surgery 1999, May 6-8. UT Southwestern Medical Center at Dallas, Excellence in Education Foundation Auditorium, Simmons Biomedical Research Building. Course director: Erwin Thal, M.D. CME credit offered. Contact: Leah Cannon, program coordinator (214) 648-3792.

Southwestern Center for Minimally Invasive Surgery: Splenectomy-Laparoscopic Advances, May 8-9. UT Southwestern Medical Center at Dallas, Excellence in Education Foundation Auditorium, Simmons Biomedical Research Building. Course director: Daniel Jones, M.D. Contact: Leah Cannon, program coordinator (214) 648-3792.

18th Annual Current Issues in Surgical Pathology, May 13-15. Sponsored by UT Southwestern Medical Center at Dallas. Westin Galleria Hotel, Dallas, Texas. Course director: Jorge Albores Saavedra, M.D. CME Credit offered. Contact: Jim O'Reilly, program coordinator (214) 648-3794.

Southwestern Orthopaedic Surgery Board Review, May 14-16. Sponsored by UT Southwestern Medical Center at Dallas. Wyndham Anatole Hotel, Dallas, Texas. Course directors: Daniel Jones, M.D. and M.B. Henley, M.D. CME credit offered. Contact: Lisa Dunlevy, program coordinator (214) 648-9532.

Southwestern Center for Minimally Invasive Surgery: Urology, June 4-5. Sponsored by UT Southwestern Medical Center at Dallas. Excellence in Education Foundation Auditorium, Simmons Biomedical Research Building. Course Director: Margaaret Pearle, MD, AMA credit offered. Contact: Leah Cannon, program coordinator (214) 648-3792.

Science of Family Medicine, June 9-13. Sponsored by UT Southwestern Medical Center at Dallas. Excellence in Education Foundation Auditorium, Simmons Biomedical Research Building. Course director: Claire McCluggage, MD, and Joe Ventimiglia, MD. AMA and AAFP credit offered. Contact: Lisa Dunlevy, program coordinator, (214) 648-9532.

Update in Pain Management, June 12. Sponsored by UT Southwestern Medical Center at Dallas. Excellence in Education Foundation Auditorium, Simmons Biomedical Research Building. Course director: Noor Gajraj, MD. AMA and AAFP credit offered. Contact: Stacey Novotny, program coordinator, (214) 648-3784.

The Third Annual Enhancing Your Clinic Practice Using New Technology, June 19 (pre-conference June 18). Sponsored by UT Southwestern Medical Center at Dallas. McDermott Plaza, D1.700. Course director: Ron Peshock, MD. CME credit offered. Contact: Kraig Steubing, program coordinator, (214) 648-9350.

Physicians at the Crossroads, June 25. Sponsored by the Alliance for Medical Management Education. UT Southwestern Medical Center at Dallas, Excellence in Education Foundation Auditorium, Simmons Biomedical Research Building. Course director: Willis Maddrey, MD. AMA credit offered. Contact Kathy Matthews, program coordinator, (214) 648-2200.

Zale Lipshy University Hospital Minimally Invasive Surgery Overview for the Primary Care Physician, June 26. Sponsored by the Southwestern Center for Minimally Invasive Surgery, UT Southwestern Medical Center at Dallas, Excellence in Education Foundation Auditorium, Simmons Biomedical Research Building. Course director: Daniel Jones, MD. CME credit offered. Contact Kathy Matthews, program coordinator, (214) 648-2200.

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BackTalk

Question

Who are your heroes and why?

"Mother Teresa, because she showed us the good side of humanity. If we admire her, maybe we'll do the same thing she did — care for the poor and needy."

Ali Moshtaghi, MD, 54
urological surgery, Wichita Falls

"Ignaz Semmelweis, who realized that hand-washing could save thousands of women who were dying of childbed fever. He tried in vain to convince the medical establishment of his findings. It was not until decades later that he was proven right. He died believing in his principles, despite the derision of his colleagues. He is the great tragic hero of medicine."

James S. Newman, MD, 39
internal medicine, Dickinson

"Every single human being around the world who makes his or her living by working with dignity and honesty and doesn't take advantage of the disadvantaged."

Juan A. Ortega-Mora, MD, 56
pediatrics, Houston

"Our founding fathers — they made a pledge to stand by their conviction for freedom, risking their lives, their fortunes, and their sacred honor. They honored that pledge, lost much, but gained everything."

John P. Trowbridge, MD, 52
medical toxicology/preventive medicine, Humble

"Bryan Williams, MD, former associate dean of students at UT Southwestern Medical School. He is a best friend to all. He did everything from letting people borrow his truck to confronting unreasonable faculty professors. He also was the star in many senior films!"

Andrew C. Sambell, MD, 34
urological surgery, Ennis

"My No. 1 hero is my mom because she's never lost faith in me. Another hero is Ms Baca, my fifth-grade teacher. She convinced me to believe in my ability to do anything I want to do."

Josie Williams, MD, 57
gastroenterology, Austin

"My heroes are many: my parents who nurtured and encouraged me; my teachers who educated me — Dr Robert S. Sparkman, my chief, in particular; and my colleagues in medicine who stay the course in spite of the many incursions into medicine today."

John C. O'Brien, Jr, MD, 56
surgical oncology, Dallas

"At the present time, my heroes are the people who are fighting against managed care. That includes my patients, who have to fight to get needed treatment. These days, if patients aren't independently wealthy, getting mental health care truly becomes a battle. My heroes also are the physicians and advocates who are standing up against the obstruction of good health care."

Deborah Peel, MD, 47
psychoanalysis, Austin

Back Talk is a nonscientific sampling of Texas physicians' opinions on a topic of interest. Physicians are polled by telephone, fax, or e-mail. We welcome suggestions for future topics. Send them to *Texas Medicine*, Back Talk, 401 W 15th St, Austin, TX 78701; fax them to (512) 370-1632; or e-mail them to m_mcever@texmed.org.

See special insert on "Essential Elements of a Quality Health Plan"

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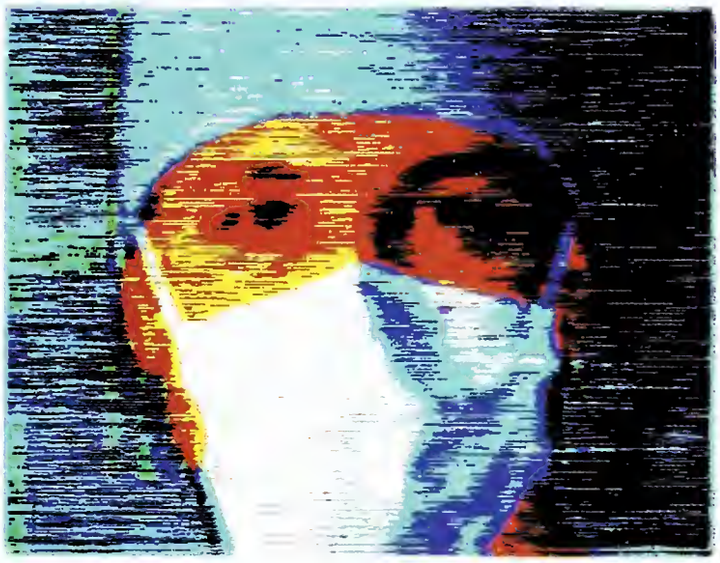

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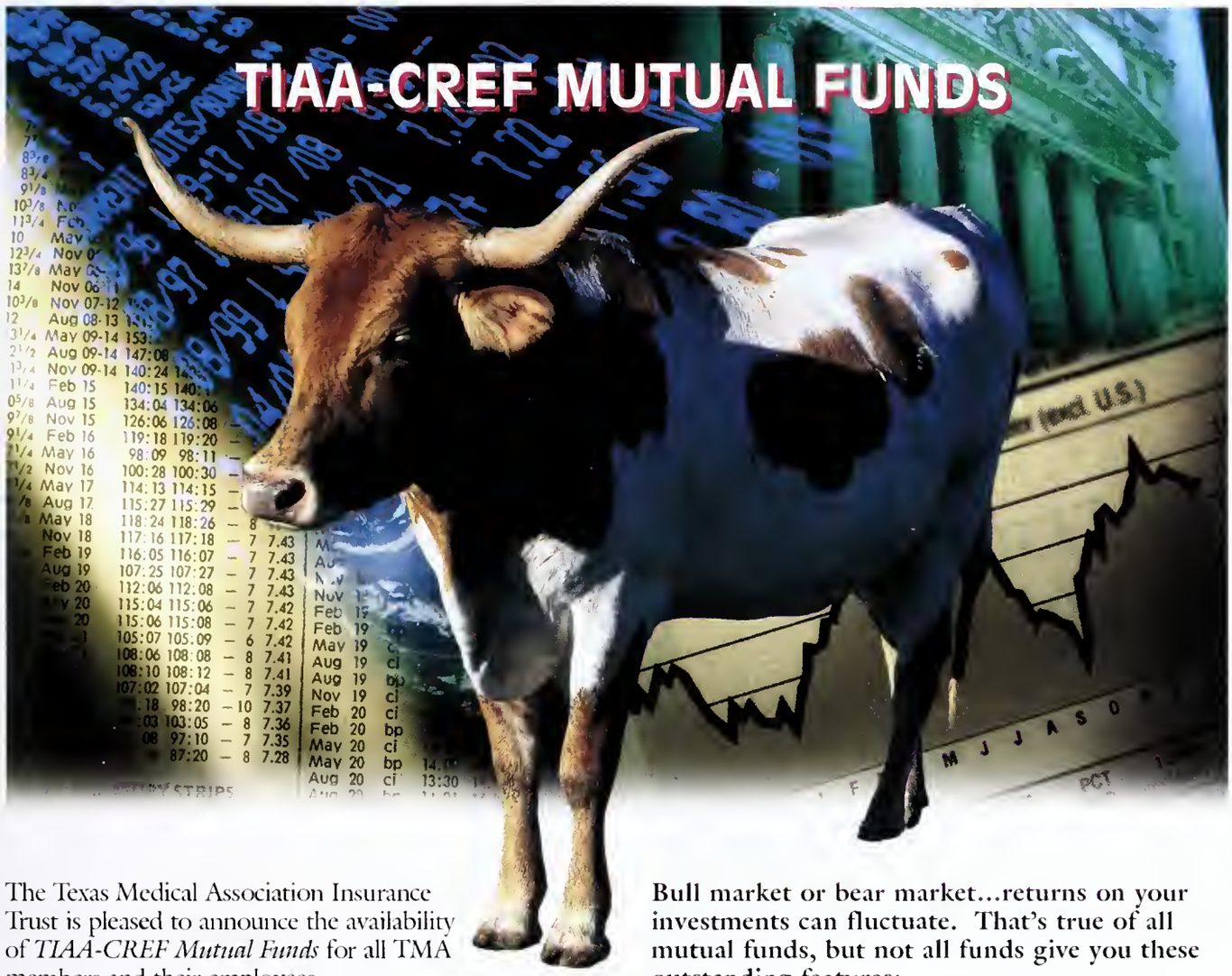

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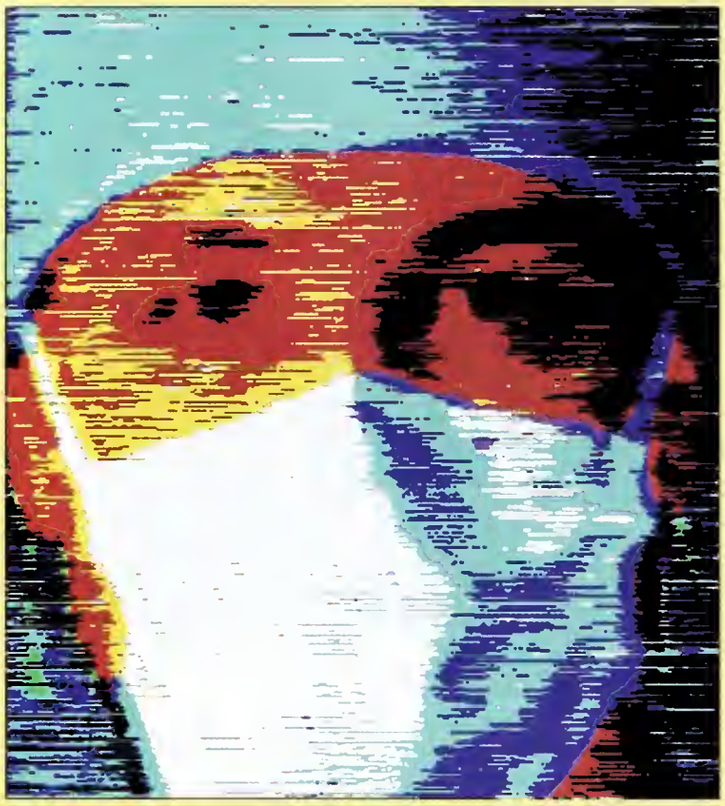

Physicians on the Internet

From conducting medical research to communicating with patients and colleagues to streamlining their office operations, a growing number of physicians are learning that the Internet is a valuable tool in their practices. Some say employing the powers of the World Wide Web is fast becoming a necessity for physicians.

By Laurie Stoneham

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Medical Economics

HMO financing 32

Some HMOs are walking a financial tight rope and when they fall, they often take physicians and patients with them. Just ask the folks in San Antonio about Well-Choice. A bill working its way through the state legislature would create stricter capitalization requirements for HMOs operating in Texas.

By Teri Moran

Medical Economics

Comparing HMOs 45

It's fashionable to bash managed care these days, but the fact is, managed care plans are not all alike. Some, like Temple's Scott & White, do it right because they keep physicians in charge of the decision-making. A special insert outlines the "Essential Elements of a Quality Health Plan."

By Teri Moran

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For a group of doctors in Fort Worth, signing up with a physician practice management company seemed like a good idea at the time. But now they are embroiled in what promises to be a lengthy battle to get out of what they have come to view as an unfavorable contract. The outcome could affect physicians throughout Texas.

By Monica Maldonado

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State legislators, along with other state officials and a few of their federal counterparts, are making an effort to improve health conditions along the Rio Grande. And it doesn't hurt that the governor has made Texas-Mexico border issues a top priority this year.

By Ken Ortolon

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The Big Picture

Alley in Roussillon, France, by Stephen F. Hoffmann, MD, San Antonio
If you would like to submit a photograph for The Big Picture, please send it to Laura J. Albrecht, Photo Editor, *Texas Medicine*, 401 W 15th St, Austin, TX 78701.

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Editor's Note

You know who you are. You're the people who hold computers in the same regard you would a rattlesnake in your refrigerator. Some of you don't even trust typewriters. But you'd better look out because the Internet posse is about to track you down.

As freelance writer Laurie Stoneham points out in the cover story this month, more and more physicians are finding out the World Wide Web is a great place for research and for communicating with patients and colleagues. Some experts even predict that some day soon patients will be able to visit their physicians via the Internet and not even have to leave their homes. How's that for a house call in reverse?

Read Laurie's story and maybe you'll be ready for some Web surfing of your own.

This issue also marks the debut of our newest associate editor, Monica Maldonado, with a story about the efforts of a group of Fort Worth physicians to break free of an onerous contract with a physician practice management company. Monica, a native Texan who had the good sense to come home from New York City, will be handling the Law and Science/Education sections of *Texas Medicine*. We're glad she's here.

Larry BeSaw
Managing Editor

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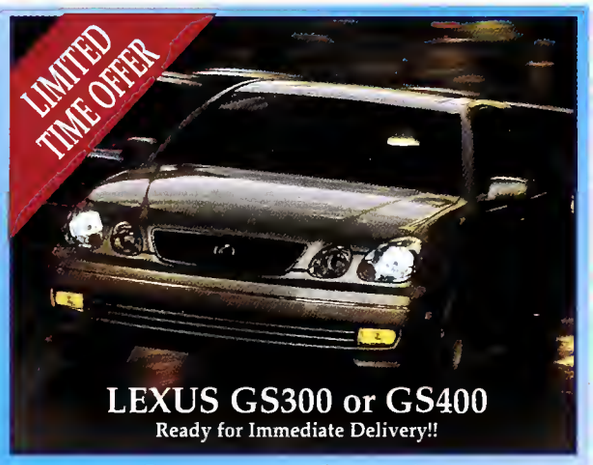

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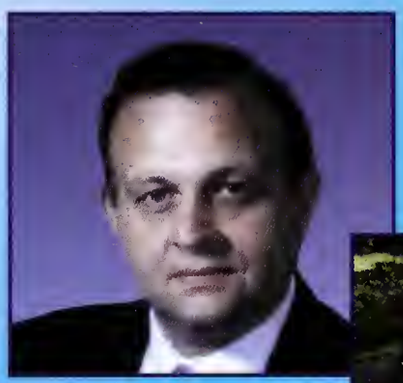

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Letters

The cover was nice

The February issue of *Texas Medicine* is evidence of where George Lundberg, MD, has landed. Article after article with the usual self-satisfied elitist, leftist view. I protest for the conservative remnants of the Texas Medical Association, which find the socialist claptrap funny, but irritating at the same time. I also apologize in advance for the length of this letter, but it is only rarely that one would find the need to criticize so much in one small journal.

The article "Swapping for Life" (pp 52–55) by Teri Moran on needle exchange programs celebrates the TMA House of Delegates action supporting this illegal concept, without mentioning important things that Ms Moran knew when she wrote the article.

- The resolution was forwarded by the Committee on Infectious Diseases 1 year after I warned the Council on Public Health that this idea was bad — rejected by the White House drug czar, Bill Bennett, and US Rep Charlie Rangel (D-NY), for example, and condemned by researchers who found the exchange programs increased the new cases of AIDS in three different studies and created law enforcement chaos by creating safe zones for drug dealing. The House of Delegates wasn't working with the panoply of information.
- The action of the House of Delegates was taken as a result of very poor and one-sided information and research, and passed without debate or discussion in the reference committee.

Ms Moran put the best face on it by quoting the supporters and bypassing the significant research I sent to TMA that raised significant questions about needle exchange. I am impressed with how quickly *Texas Medicine* rushed in to congratulate TMA on its action. Where was *Texas Medicine* when the House of Delegates condemned in resolutions the poor science of the patient safety movement or when the House condemned the Kidcare crisis rhetoric or warned that the Environmental Protection Agency regulatory activity should be closely watched for junk science? It's easy for me to guess, since the editorial board or the staff seems to support big government, a larger welfare state, and more regulations.

In the same issue, Cynthia Meyers in her article, "After Hopwood," (pp 56–59) stretched the truth and revisited another campaign for an illegal concept held in high regard by the left — color quotas. No research supports Ms Meyers' assertion that minority populations are less likely to seek medical care from white doctors — people aren't stupid, they go to *good* doctors when they can find them and *kind* doctors in preference to unkind ones.

No legitimate research exists that says that black or Hispanic patients are more likely to follow the recommendations of a physician from the same ethnic background as opposed to a white doctor. This politically correct ranting has to stop. I challenge Ms Meyers' statements and sources to a duel — even if they managed to manufacture proof of their prejudice, it is still evil racism promoted for perverse reasons.

On enrollment changes, the article pointed out the obvious. If poorly qualified individuals are allowed into law

I think the least that the medical profession in Texas can do is assure everyone that they will be dealing with properly qualified and well-trained physicians when they go into doctors' offices.

Express your point of view in *Texas Medicine*. To submit a letter, mail, fax, or e-mail it to *Texas Medicine*, TMA, 401 W 15th St, Austin, TX 78701; fax (512) 370-1632; e-mail larry_b@texmed.org. Please type letters you submit for publication, and keep the length to 400 words or less. If necessary, you may include a few references, preferably less than five. Letters are published at the discretion of the managing editor and editorial advisors, and are subject to editing and abridgment. Letters represent the opinions of the authors and do not necessarily reflect the policies of the Texas Medical Association.

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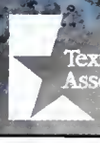

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Letters

school or medical school on the basis of color and if that is outlawed, then obviously there will be a decline in that group's enrollment. Would Ms Meyers or *Texas Medicine* suggest that we send poorly qualified ethnic doctors into the ethnic neighborhoods on the theory that the ethnic neighborhoods need inferior doctors?

Any ethnic group should get no less than a properly qualified physician. Any system that ignores the importance of competence and adequate preparation is, in fact, another form of plantation racism. Sometimes, for all the good reasons in the world, we do crazy things, and I think the least that the medical profession in Texas can do is assure everyone that they will be dealing with properly qualified and well-trained physicians when they go into doctors' offices. The last thing we need is *Texas Medicine* continuing this whining about the demise of quotas. Quotas are over, and Ms Meyers properly pointed out the real solution — help people of all groups achieve an adequate education.

All efforts to increase participation in the great American opportunity should be encouraged. *Texas Medicine* should emphasize the importance of improving the Texas educational system at the grade school and high school levels for children everywhere in Texas, so that we can avoid one half of Texas college students requiring remediation. All efforts to put a hand out and give a hand up to kids who come from deprived circumstances should be applauded and supported. Quotas smell of condescension and white liberal elitism, and I know for a fact that there are black doctors and Hispanic doctors in TMA who are smarter than me by a mile — don't demean them with your silly journalistic biases.

It's time for us to give up all this stylish multiculturalism and "diversityism" and reach for a color-blind and nondiscriminatory ideal rather than dredging up old resentments or unrequited guilt that serves no purpose but to allow manipulation and rhetorical bullying.

Last but not least, Larry BeSaw presents the article, "Checking the Pulse,"

(pp 60–62). Will journalists ever stop finding a new crisis created by agenda-driven advocacy groups so that expanded government can rush in to save the day? The House of Delegates recently passed resolutions condemning the crisis rhetoric related to child insurance and supporting the free-market approach to insurance. Did *Texas Medicine* write an article on those timely resolutions?

I suggest that you reevaluate, regroup, and temper some of the editorial biases and prejudices demonstrated in the February 1999 issue.

John Dale Dunn, MD, JD
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Lake Brownwood, TX 76801

Team approach is best

Somehow a copy of the March issue of *Texas Medicine* ended up in my mailbox. I read with interest the article on cooperation between physicians and pharmacists in an effort to avoid legislative battles ("Prescription for Cooperation," March 1999 *Texas Medicine,* pp 54–56).

The existing agreement of "physicians should prescribe and pharmacists should dispense" that has kept the peace for several years made me chuckle, then made me a little frustrated. That "agreement" has very little in common with the training I received in pharmacy school or with the practice that I have had during the last 14 years in a hospital setting. In my own experience, the rule that might benefit patients most would be "physicians should diagnose and pharmacists should prescribe." It also is interesting to watch the increased use of other physician extenders who are given prescribing privileges with a lot less training in pharmacotherapy than that received by pharmacists.

Clearly, as stated in the article, the focus should be on what's best for the patient. In my experience, a team approach that includes a pharmacist is almost always the optimal approach. Pharmacy-run services that operate under carefully developed protocols approved by physicians are proliferating

Transitions: Legal Considerations in Selling or Closing a Medical Practice
by Hugh M. Barton, JD

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because they have been shown to work. Anticoagulation clinics, hypertension clinics, lipid clinics, asthma clinics, and many others are being developed because they are cost-effective.

The focus now should be ensuring that the pharmacist has the proper training and competence required of the task. The profession of pharmacy already has developed ways to do this through doctor of pharmacy programs, general and specialized residency programs, and methods for board certification and specialty certifications.

While there is remaining work to be done, it is not in the best interest of the patient to allow turf battles to intervene or to continue to suggest that "pharmacists should stick to dispensing."

Jeffrey J. Weber, PharmD, BCPS
Clinical Pharmacy Specialist
2715 Aspen Lane
Pearland, TX 77584

Still enjoying his practice

George Bohmfalk, MD, who wrote about giving up the practice of medicine ("I Just Had to Let It Go," March 1999 *Texas Medicine*, pp 45, 48–49), is my contemporary. I knew George very well about 25 years ago because he was a medical school classmate. George has always been a man of many talents, so his choice to move on to other areas of interest does not surprise me. Also, being of an energetic sort, George chose a career in perhaps the most demanding of specialties, neurosurgery. Surely stress-related "burnout" must be more common in such a specialty. All I can say is, if George Bohmfalk is now opening a restaurant, I'll drive across the state, based on the man I have always known, to dine there (and I promise, George, not to criticize the food).

My own practice in ophthalmology is probably less demanding and, to some at least, less respectable as well. Recently, at a men's lunch club, the program listed my occupation as "physician." In introducing me, the moderator said, "Danny isn't really a physician, he's an eye doctor!" So there you have it. Even so, I do not plan to give up practicing during the foreseeable future. Eventually, I hope to free up more extended time out of the office for travel, but I will also enjoy having an office to return to. Each of us knows what we give to our patients, but we often overlook what our patients give to us — a purpose.

A few weeks ago, I replaced my old phoropters (instruments used to test for glasses) with new ones. After 21 years of consistent service, the instruments began showing various malfunctions. To my distress, I discovered that replacement parts are no longer made for these phoropters. When the cylinder mechanism irreparably locked up one day, I purchased new ones. It seemed a rather optimistic, even extravagant expenditure at my age, considering the old ones lasted for 20 years.

Since retirement, disability, and death have decimated the ranks of the more senior ophthalmologists in San Antonio, I now find myself, by default, within the ranks of the more senior ophthalmologists. My practice, still solo now for all these years, is as comfortable as an old pair of bedroom slippers. Patients whose tear ducts I probed as babies now have their own babies. I have worked long enough to watch vibrant, alert, productive elderly patients decline to states approaching that of pet rocks. "Are you having a good day?" "Every day above ground is a good day," one observed. Some glaucoma victims have progressively lost vision under my careful watch, despite the best treatment available. Patients often let me know that they fear blindness more than death. I now not only accept intellectually, but also with the heart, that a humbling balance of successes and failures as we take care of folks is preordained and, therefore, to a large extent, beyond our control. The assimilation of that truth can and should be quite relaxing.

Fortunately, I enjoy many interests outside the practice of ophthalmology. I still keep up piano playing because, more than anything else, my friends enjoy the music and encourage me. Last year, I participated in a Doctor's Concert, sponsored by the Department of Music at The University of Texas at San Antonio. At the end of the performance, I was actually handed a bouquet of roses. I have never received flowers following even the most successfully performed cataract surgery. Roses and a little applause do lift the spirit. In my neighborhood, the Alamo Heights High School golf team fields several talented young golfers, and I have taken on their support as a project. My own golf game provides sufficient frustration for those days when I am not in the office. Then there are photography and cooking.

I now not only accept intellectually, but also with the heart, that a humbling balance of successes and failures as we take care of folks is preordained and, therefore, to a large extent, beyond our control.

Back to the phoropters. I'll have to confess, with all the administrative hassles, and now that I am among the senior practitioners, the "R" word occasionally has crept into my conversation as well. I'm not sure I can explain it, but since I now have this infusion of new equipment, I go to the office most days with an attitude I once enjoyed but somehow lost along the way, and that is meeting the workday with a sense of open-ended possibility and adventure. Besides, I have new equipment to pay for! And not to forget, every day above ground is a good day.

Daniel G. Duke, MD
8601 Village Dr, Ste 212
San Antonio, TX 78217

Commentary

An era of insurgency in medicine

By Robert T. Gunby, Jr, MD

It is an honor to be here to share the experiences of the Dallas County Medical Society (DCMS) during our members' ongoing battle with Aetna US Healthcare. Unfortunately, this is a common story among physicians, covered by media all over the United States. But in typical Texas style, it has been bigger here than in other parts of the country. The sheer size makes the impact on patients and physicians easier to see and less anecdotal.

Since I intend to frame this story in terms of a battle, I wish I could mimic the great US Gen George Patton as well as George C. Scott did. I would love to use a few of Patton's choice adjectives to describe the Wall Street strong-arm behavior that we have witnessed in the last 8 months. Instead, I'll simply use the metaphor of a battle because it feels very appropriate. As our members fought this well-armed and well-funded opponent last summer, they called upon all levels of organized medicine for assistance. So, if I may, I would like to tell you how our county medical society, state medical association, and the American Medical Association have worked together to support these physicians.

First, let me give you a little background. In 1998, I was privileged to serve as DCMS president and represent the 6,000 members in our community who treat patients everyday. Last June, the medical society was notified by the leadership of one of the county's largest groups that its attempt to work with Aetna in a risk-sharing contract was failing. This 560-physician group, known as Genesis Physicians Practice Association, had many managed care contracts using the messenger model. But one of the contracts was a risk-sharing, capitated contract with Aetna's health maintenance organization (HMO). The group had integrated clinically, and its members used a Texas law that allowed them to take such a contract and act as a single negotiating entity.

Shortly after Aetna took over the operations of US Healthcare, Genesis' relationship with Aetna deteriorated. After a year of operating under this agreement, Aetna would not, or could not, provide the information Genesis needed to manage costs. It was like trying to drive at night without headlights. Aetna's inability to share needed information brought new meaning to the concept of taking on a risk contract.

The Genesis leaders soon voted to terminate their HMO risk contract with Aetna, but Aetna refused to honor their notice and promptly turned around and issued its own termination notice, in essence firing all 560 physicians and giving them until October 12 to sign individual contracts or be dropped from the network. So, in that terribly hot, El Niño summer, more than the temperature was starting to boil in Dallas. But it was Aetna's next action that would cause Genesis to seek the support of organized medicine. Fortunately, we were ready and willing to help.

In a move that has come to epitomize the greed of these Wall Street health care behemoths, Aetna officials not so subtly told physicians that it was "our way or the highway," as they im-

It was like trying to drive at night without headlights. Aetna's inability to share needed information brought new meaning to the concept of taking on a risk contract.

Editor's Note: Dr Gunby gave this speech at the AMA National Leadership Development Conference in Phoenix on March 21.

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posed their "all-or-nothing" policy they call an "All Products" provision. With this single, bullish corporate decision, the number of patients affected by this dispute rose from 8,000 HMO patients to 40,000 HMO, preferred provider organization, and point-of-service patients. Physicians found themselves threatened with losing larger percentages of their practices if they did not sign individual HMO agreements. Patients found themselves as pawns in the battle between David and Goliath.

Telling the public

DCMS leadership believed Aetna's threat to impose its corporate policy on an additional 32,000-plus patients was morally wrong. Such behavior had to be publicly exposed, and the best vehicle available to us was the media. So, on July 9, 1998, DCMS held its first press conference in 15 years to expose and oppose corporate tactics, which would cause massive disruptions of patient-physician relationships, all in order to coerce physicians into an unreasonable HMO contract.

You need to be aware that this is the same managed care organization that has fought reforms each and every step of the way. This organization filed a lawsuit in Texas opposing the 1997 law that allows patients the right to sue their HMOs if they are negligent in the decisions they make regarding patient care. Aetna has spent millions of dollars in Washington, DC, pushing legislation that would undo the patient protection laws that Texas and dozens of other states have passed. We knew going into the battle that Aetna fights with a great deal of intensity. We needed to be serious and strong in our condemnation of its actions.

The resulting press conference certainly was successful in getting the word out. Every type of media in Dallas covered the event, including radio, print, and television. The noon, 5, 6, and 10 o'clock news covered our position as the top story. Aetna had no response. Since the summer of 1998, this story has been retold and updated in dozens of national publications, including the *New York Times*, *The Wall Street*

Journal, and ABC's "World News Tonight" and "20/20."

But the media attention alone was not enough to stop Aetna from imposing the take-it-or-leave-it policy, and on October 12, thousands of Dallas patients received letters telling them they had lost their physicians. Of the 560 Genesis physicians, only 110 had signed individual contracts. Genesis had survived its toughest battle.

By November, Aetna was buying newspaper ads bragging that it had the largest network in North Texas, but it also was paying high-powered Washington attorneys to draft a seven-page letter threatening antitrust action against Genesis for destroying the network. The letter, along with the individual contract, was shared with physicians during personal visits from Aetna recruiters.

Genesis physicians remain confident that their group will survive. They continue to meet with Aetna to explore ways to find a solution.

Yet, the horizon is darker for Genesis, and indeed for physicians all across the nation, with the prospects of Aetna's merger with Prudential. In Dallas, after the merger, the conglomerate that may be Aetna/US Healthcare/NYLCare/Prudential will hold 47% of the commercial insurance market. In Houston, the market share will exceed 60%. These market imbalances put tremendous pressure on physicians when they look at their practices. It makes even the smartest physician rethink whether or not to sign a one-sided contract.

That is why DCMS and the Texas Medical Association supported AMA's action to oppose the merger of Aetna and Prudential. It is time these multibillion-dollar corporations stop running to the federal government every time a small group of physicians speak out. Our goal has been to create the opportunities for this change. It is time for the laws to look out for the patients who are being affected as this battle continues to grow.

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new focus within the organizations of the federation. The collaborative efforts of the county society, TMA, and AMA have improved with each step of the battle.

It was very tough going at first, but now the efforts and support of the AMA's Private Sector Advocacy Department are tangible benefits to thousands of DCMS members. DCMS acts as the communications coordinators, informing TMA and AMA of battlefield conditions, and passing back strategic information from AMA to the grassroots. Biweekly conference calls are set up by DCMS that include TMA, AMA advocacy staff, and the leaders of Genesis. TMA provides the statewide perspective and its incredible lobbying, legal, and communications talent. And, AMA's national perspective and depth of expertise in legal and antitrust issues are invaluable. In fact, it was an awesome sight to witness the talent of all levels of the federation gathered at DCMS headquarters the night before the press conference last summer. The messages they crafted that evening are still alive in the media today. It was federation collaboration at its best.

Throughout these past months it has been clear to me, and to all those who have worked so hard doing this, that this is one of the primary reasons organized medicine exists. This is the type of cooperation and focused advocacy that we need, expect, and want from our organizations. There is room for all our organizations in the process. Everyone needs to be involved and focused on our patients. It is not easy, but nothing worth doing ever is. County and state associations first must be willing to work together and then fully partner with AMA and specialty societies to accomplish our goals.

We sometimes feel like French resistance fighters in World War II. The enemy is bigger and better equipped than we are, but our determination to overcome these odds can make us victorious in the end. ★

People

Newsmakers

Otolaryngologist **Edward E. Bellens, MD,** and pediatrician **Robert E. Myers, MD,** both of Temple, were honored at a Doctor's Day '99 dinner by the Bell County Medical Society and the Medical Alliance of Bell County.

Dallas orthopedic surgeon **Phil H. Berry, Jr, MD,** was honored by the Medical Advisory Board of the National Kidney Foundation of Texas at its Champions of Hope Tribute Gala, which benefits the foundation's research grant program.

Wylie family practitioner **Mary Birdsong, MD,** was named Best Doctor for the third year by "The Best of Wylie Area" 1999 readers poll.

General practitioner **Roy E. Bohl, MD,** received a proclamation from the City of Midlothian upon his retirement for his 34 faithful years of service.

Houston general surgeon **Vergel V. Cruz, MD,** was elected president of the Houston Chapter of the Texas Association of Philippine Physicians.

Austin gastroenterologist **Shad Dabaghi, MD,** received the Freshman Governor's Award from the American College of Gastroenterology.

Phil H. Berry, Jr, MD

Christopher L. Jagmin, MD

Houston cardiothoracic surgeon **Michael E. DeBakey, MD,** received the 1999 John P. McGovern Compleat Physician Award. Also, Baylor College of Medicine's Board of Trustees will rename Baylor's Department of Surgery after Dr DeBakey.

Houston internist **Harold E. Gottlieb, MD,** was named associate medical director of CIGNA HealthCare of Texas.

The 1999–2000 Texas Neurological Society officers include **Martin Heitzman, MD,** El Paso, president; **J. Douglas Hudson, MD,** Austin, president-elect; **Eugene Chi-Ho Lai, MD,** Houston, vice president; and **William H. Fleming III, MD,** Houston, secretary-treasurer.

Family practitioner **Christopher L. Jagmin, MD,** was appointed network medical director for Aetna US Healthcare's North Texas Division in Dallas.

Mark J. Kubala, MD

Gary Lusk, MD

Laurance N. Nickey, MD

J. Marc Shabot, MD

Houston general practitioner **Gulam M. Khan, MD,** was named president of the Houston Chapter of the Islamic Medical Association.

Douglas D. Koch, MD, was appointed to The Allen, Mosbacher, and Law Chair in Ophthalmology at Baylor College of Medicine in Houston.

Beaumont neurosurgeon **Mark J. Kubala, MD,** received the J.C. Crager Award from the Golden Triangle Region American Heart Association.

Houston pediatrician **James R. Lupski, MD,** received the 1998 E. Mead Johnson Award for Research in Pediatrics from the Society of Pediatric Research.

Please let *Texas Medicine* know about your honors and achievements. Criteria for inclusion in the Newsmakers section are TMA membership; election or appointment to an office of, or honors from, a national or state organization; or, space permitting, recognition at the local level. Items for the Newsmakers section are published at the discretion of the managing editor. Submit items for consideration, with photos if possible, to Johanna Franke, People, *Texas Medicine*, 401 W 15th St, Austin, TX 78701; fax (512) 370-1632; e-mail johanna_f@texmed.org.

TexasMedical Association

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People

Austin psychiatrist **Gary Lusk, MD,** received the 1998 Roger McCary Physician Excellence Award from Seton Shoal Creek Hospital for his integrity, clinical excellence, active participation in physician management activities, and good citizenship.

Pasadena general surgeon **Dixie Melillo, MD,** was recognized by Gov George W. Bush and First Lady Laura Bush as a new member of the Texas Women's Hall of Fame, which honors women who have attained outstanding levels of achievement and whose contributions have made a significant impact on the lives of Texans.

Houston urologist **Ronald A. Morton, Jr, MD,** received the Researcher Award from the American Cancer Society and 100 Black Men of America, Inc.

El Paso pediatrician **Laurance N. Nickey, MD,** was appointed to the US Section of the United States-Mexico Border Health Commission by President Bill Clinton.

Donald A. Podoloff, MD, Houston, was named president of the American College of Nuclear Physicians.

Galveston gastroenterologist **J. Marc Shabot, MD,** was elected governor of the Texas Southern Region of the Texas Chapter of the American College of Physicians-American Society of Internal Medicine.

Houston pediatrician **Huda Y. Zoghbi, MD,** was presented the Sidney Carter Award from the American Academy of Neurology.

Deaths

James Lee Baldwin, MD, 75; Dallas; The University of Texas Southwestern Medical School at Dallas, 1947; died February 15, 1999.

Anthony Wayne Beal, MD, 82; Houston; Meharry Medical College School of Medicine, 1943; died February 22, 1999.

People

Carroll Leon Boone, MD, 76; Friendswood; The University of Texas Southwestern Medical School at Dallas, 1953; died February 25, 1999.

Dewitt Walker Cox, Jr, MD, 79; Houston; The University of Texas Medical Branch at Galveston, 1948; died February 22, 1999.

Hulen Porter Crumpler, MD, 84; Bowie; The University of Texas Medical Branch at Galveston, 1938; died January 28, 1999.

Isaac Meyer Gans, MD, 65; Dallas; University of Cape Town-Republic of South Africa, 1956; died February 2, 1999.

Evalea Glanges, MD, 59; Fort Worth; The University of Texas Southwestern Medical School at Dallas, 1966; died February 27, 1999.

Carlton Eugene Hardey, MD, 72; Arlington; The University of Texas Southwestern Medical School at Dallas, 1952; died February 12, 1999.

Alfredo L. Juan, MD, 52; Pampa; University of Santo Tomas-Philippines, 1971; died February 19, 1999.

John Ferman McNeely, MD, 74; Pasadena; Baylor College of Medicine, 1952; died February 17, 1999.

Walter Stewart Miller, Jr, MD, 86; Denton; The University of Texas Medical Branch at Galveston, 1937; died March 2, 1999.

Edwin Leo Mueller, MD, 100; San Antonio; Saint Louis University School of Medicine, 1921; died February 17, 1999.

Allan Huddleston Neighbors, Jr, MD, 79; Austin; The University of Texas Medical Branch at Galveston, 1943; died February 27, 1999.

Alfred Sigmund Wolfe, MD, 84; Henderson; Baylor College of Medicine, 1938; died February 24, 1999.

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Texas Medicine Rounds

By Johanna Franke

The patient's perspective

Texas Supreme Court justice describes how he was put first

The more than 500 physicians attending Texas Medical Association's Winter Leadership Conference on February 27 in Austin heard a very special keynote speaker. He wasn't a physician, a health care administrator, or a communication specialist. He was a patient, who was very grateful for the "tremendous" care his physicians have provided him over the years.

Texas Supreme Court Justice Greg Abbott has interacted with physicians often since he became partially paralyzed when struck by a falling tree while jogging in 1984 at the age of 27. His experiences with the medical profession have made him an expert on putting patients first.

With help from his family, friends, and physicians, Justice Abbott continued his career, which included twice being rated as the most outstanding state judge in Harris County, being named Appellate Judge of the Year by the American Board of Trial Advocates-Texas Chapter, and being honored as one of five Outstanding Young Texans by the Texas Jaycees, all before becoming a Supreme Court justice on January 1, 1996.

At the winter leadership conference, Justice Abbott presented a "case study on putting a patient first" that began more than 2 years ago when he made a trip to an Austin hospital emergency department because of a persistent high fever.

"It was discovered that I had a very serious decubitus ulcer on my sitting area that wasn't going to go away in a day or two as I had hoped," Justice Abbott said. Austin plastic surgeon Patrick Beckham, MD, was called in to treat the wound — and the patient.

"He didn't treat me as though I did not know what was going on," Justice Abbott said. "He appreciated the concept that I knew what a decubitus ulcer was and he explained all the various options to me in a way that I could understand them."

Because of his busy schedule as a Texas Supreme Court judge and a professor of constitutional law at The University of Texas School of Law, Justice Abbott turned down Dr Beckham's first treatment suggestion — surgery followed by a 5-week or so recovery face-down in a hospital bed.

"Dr Beckham was calm, he was relaxed, and he was undeterred because his focus was on trying to heal me, but at the same time — and this was something I was very appreciative about — he wanted to heal me in the method that would be most accommodating for the lifestyle that I wanted to pursue at that particular time, which was not to be confined to a hospital bed for more than a month," Justice Abbott said.

> "Dr Beckham took into consideration all of these various factors and took the time to explain all of my options to me. He basically dealt with me in a way where we were a team together deciding on the best form of care for me."

By keeping up with the latest technology for repairing this type of wound, Dr Beckham knew to suggest treatment with a vacuum-assisted closure (VAC) device. That allowed Justice Abbott to heal in the privacy of his

own home as well as to get up periodically to use the bathroom, take a shower, and play briefly with his then 1-month-old baby.

"Dr Beckham took into consideration all of these various factors and took the time to explain all of my options to me," he said. "He basically dealt with me in a way where we were a team together deciding on the best form of care for me."

During the treatment, Dr Beckham dropped by Justice Abbott's house once a week to check on the wound and make sure he was taking the proper vitamins. "Doctors making house calls — especially surgeons making house calls — that's something I didn't think existed anymore," Justice Abbott said.

He also was impressed by how informed his home health care nurses were and how well they worked with Dr Beckham. "Nursing care is so important as well as the perception of the interrelationship between doctors and nurses," Justice Abbott said. "Many patients believe that the way nurses treat patients is tied to the interrelationship between doctors and nurses, so please remember that with regard to your care of patients in the future."

After 2 months working with the VAC, Justice Abbott ran out of patience and underwent surgery to speed up the healing process. But the procedure was nowhere near as dramatic as the initial surgery would have been, he said.

In the hospital, Dr Beckham continued to treat Justice Abbott with respect. Whereas some physicians get frustrated if they arrive at a patient's room and find the patient in the middle of a visit with a family member or tending to work, Dr Beckham instead would watch television until Justice Abbott was free.

"Patients are like guests in a hospital much like guests in a hotel room," Justice Abbott said. "They're also dealing with strangers in a place they're not familiar with and are somewhat frightened of having invasive procedures done. At the same time, they're needing reassurance, care, and support from their family members. So when they receive phone calls or visits from family members, that's incredibly important."

According to the nurses who work with Dr Beckham, Justice Abbott was not receiving special treatment. "You can tell by the way Dr Beckham conducts his life that the thing he cares most about is taking care of patients so that they feel taken care of as opposed to just sewn up," Justice Abbott said.

Justice Abbott says he knows the medical profession in the '90s is changing from being practiced as a profession to being practiced as a business. The same thing happened to the legal profession in the '80s, he said. But he hopes the medical profession can avoid the legal profession's fate and that physicians can continue to put patients first despite forces such as managed care, lawsuits, and legislation.

"It would be tragic indeed if the medical profession were dragged down the same course that the legal profession has been dragged down," Justice Abbott said. "My hope is that the forces that exist in our society today — whether they be legal, legislative, or market forces — will not tread upon your right, and your ability, and your desire to continue to pursue the healing profession and to always put patients first." ★

Texas Supreme Court Justice Greg Abbott gave Texas Medical Association members tips on putting patients first at the 1999 Winter Leadership Conference. The next leadership conference will be held September 18 in Austin.

Texas Medical Association President John P. Howe III, MD, San Antonio, introduced a 5-year plan at the 1999 Winter Leadership Conference to encourage more direct care physicians to become TMA members. Though TMA represents 85% of the doctors of medicine licensed and residing in Texas, only 71% provide direct patient care every day, while the other 14% are academics, researchers, and administrators. "We need to find out why women, physicians under age 40, international medical graduates, DOs, and many others on the frontlines of patient care aren't choosing to join our association," Dr Howe said. By using Internet resources and redoubling efforts to provide relevance and value to the growing number of Texas physicians in large group practices, Dr Howe hopes to increase that 71% of direct patient care membership to 85% by the year 2005.

Marilyn Moats Kennedy, founder and managing partner of the Wilmette, Ill, consulting firm Career Strategies, discussed cross-generational communication and defined the four age-related groups in the workplace now and the fifth group that will be entering the workforce by 2000 at the 1999 Winter Leadership Conference. These groups include preboomers (born during the years 1935–1945), boomers (born between 1946 and 1959), cuspers (born between 1960 and 1965), busters (born between 1965 and 1975), and the post-TV generation (born between 1975 and 1981). "Change is coming, and it's a profound change," said Ms Kennedy, who has been quoted in *The Wall Street Journal* and has appeared on "20/20" and "Good Morning America." As busters, who distrust big business, move into leadership roles, smaller will be better and solo practices will thrive. The youngest groups are willing to pay to get the latest technology and the physicians they want, she said.

Medical staff attorney Elizabeth A. Snelson, JD, led the 2-hour "dawn duster" session at the 1999 Winter Leadership Conference with her presentation "Obsolete Medical Staff Bylaws: What You Don't Update Can Hurt You." The session was sponsored by Texas Medical Association's Organized Medical Staff Section.

TMA Council on Legislation Chair Robert W. Sloane, Jr, MD, of Fort Worth, updated TMA members on patient care issues before the 76th Texas Legislature and the 106th US Congress, and described the duties of the Council on Legislation during the state legislative session. "We look at every bill — that's roughly 1,100 before the final deadline in March," Dr Sloane said.

Peg C. Neuhauser, author of *Tribal Warfare in Organizations* and president of PCN Associates in Austin, discusses negotiating skills with TMA Board of Trustees Chair Byron L. Howard, MD, before her presentation at the 1999 Winter Leadership Conference. Ms Neuhauser said the negotiation continuum ranges from the highly adversarial down to the collaborative approach, which "is the most elegant and complicated form of communication that you're going to find anywhere." When using the collaborative approach, Ms Neuhauser says, don't insult any of the parties at the table, consider all the parties' points of view at the same time, and, when nothing else works, use humor.

Texas Health and Human Services Commissioner Don Gilbert told conference attendees that the commission will continue with the July Medicaid managed care rollout in Dallas despite questions about provider networks. "We are committed. We are contracted. We have significant liability if we stop now," he said. He also described the breakdown of the state's 2.5 million Medicaid enrollees, 60% of whom are kids. He said 600,000 of Texas' uninsured children are Medicaid eligible but are not enrolled.

Dr Anderson pledges to create 'new' AMA

When E. Ratcliffe Anderson, Jr, MD, goes to work each morning, he is reminded of what he wants the American Medical Association to be. That's because a new Nordstrom department store is going up next to AMA headquarters in downtown Chicago, and just as Nordstrom is known for unmatched customer service, Dr Anderson wants the AMA to be known for unmatched member service.

"Nordstrom's motto is 'outrageous service' in the very best sense of the word," the AMA executive vice president said during a speech at TMA's 1999 Winter Leadership Conference in February. "At AMA headquarters today, and over the months and years to come, we intend to give them a run for their money. Outrageous service for each and every AMA member physician."

Dr Anderson, who is used to tough battles from his days as a decorated Air Force fighter pilot in Vietnam, says he has "been making it my business to change the way we do business back at the AMA" ever since he became its chief executive officer 9 months ago. "Our success has to begin with the issues that matter to you, and to all physicians, on a day-to-day basis. Because if we aren't there when you call, we might as well not be there at all."

Evidence of that renewed commitment to members' needs, the former Air Force surgeon general said, are AMA's support of Dallas physicians in their dispute with Aetna, its opposition to the proposed Aetna/Prudential merger, and its efforts on fraud and abuse. "That's what every action the AMA takes now and in the future can and must be about — meeting your needs as AMA members."

Dr Anderson outlined initiatives he says will improve the AMA's responsiveness to its members. They include consolidating all phone banks and referral resources, "to make sure that when you call the AMA, you get the answers you need quickly, efficiently, and courteously," and creating a new office of member communications, "dedicated to providing AMA members with specific, targeted news you can use keyed to your mode of practice, your special interests, and your special needs." The potential of the Internet to serve and to reach members will be maximized, he said.

"What has been needed — and what is happening right now — is nothing less than a full-scale change of the culture. A sea change, if you will," Dr Anderson declared. "It's an end to the stagnant, self-serving networks of the past. Because it's just not good enough to say that we've done it that way for 150 years and more. We'd better make sure that what we do is relevant today."

Dr Anderson pledged efforts toward reaffirming quality, "not only in Washington and the marketplace, but in medicine's house as well," and "keeping faith with the principles on which organized medicine was founded." AMA also will continue working to support the Live and Then Give organ donation program, to improve the quality of end-of-life care, and to reform Medicare, he said.

"This is the kind of work that will make and keep organized medicine relevant for the 21st century. But as you know so well, it takes all of us working together to make it happen." But, he added, a strong AMA membership is the key.

"Just as the TMA is the one organization that speaks for the physicians of Texas, the AMA is the one organization that speaks for all of medicine, touching all specialties. But our voice is only as strong as our professional unity and our ability to create change only as strong as the numbers we represent."

Dr Anderson said when he and AMA President Nancy Dickey, MD, of College Station, go to Washington, "there's one thing that Congress wants to know: How many physicians do we speak for? And I'm sure they ask you the same thing over at the State Capitol. That's why, of all the priorities I've mentioned today, membership may be the most important. Because if we make membership our priority, then I am confident that we will have the power that is needed behind our physician voice."

American Medical Association Executive Vice President E. Ratcliffe Anderson, Jr, MD, addresses more than 500 TMA members at the 1999 Winter Leadership Conference.

WEB SITES OF INTEREST TO TEXAS PHYSICIANS BY JOHANNA FRANKE

MedBytes

In honor of World No Tobacco Day on May 31, "MedBytes" offers Web sites with tobacco prevention and cessation information.

CDC's tobacco TIPS

The Centers for Disease Control and Prevention (CDC) has created the Tobacco Information and Prevention Source (TIPS) at www.cdc.gov/nccdphp/osh. This site offers tips for children and teens, educational materials, guidelines on how to quit using tobacco, and tobacco research and current events.

AHCPR clinical practice guidelines

The Agency for Health Care and Policy Research (AHCPR) Web site includes several smoking cessation resources under "Clinical Practice Guidelines Online" at www.ahcpr.gov/clinic. Some of these resources include "Helping Smokers Quit: A Guide for Primary Care Physicians," "A Systems Approach: A Guide for Health Care Administrators, Insurers, Managed Care Organizations, and Purchasers," and "Smoking Cessation Consumer Tools Kit."

POEP provisions

The online tobacco resource center of Texas Medical Association's Physician Oncology Education Program (POEP) at www.texmed.org/health_science/hs_tobacco.html includes Texas-specific information on tobacco, such as legislation and mortality rates. The site also contains spit tobacco facts, information on youth and secondhand smoking, pregnancy and tobacco data, and a Texas tobacco resource catalog.

DOC tobacco resources

Information on Doctors Ought to Care (DOC), a group that provides school curricula, smoking intervention information, and tobacco counteradvertisements for use in clinics, classrooms, and communities, can be found at www.bcm.tmc.edu/doc.

Indiana Tobacco Control Center

Indiana University's tobacco control center at iumeded.med.iupui.edu/tobacco/contents.htm offers tobacco control resources and laws, a history of tobacco, and information for physicians and health care providers.

Have an idea for the TMA Web site?

TMA's Council on Communication has created the Virtual Advisory Committee for the TMA Web site to solicit suggestions from you, the TMA member, on ways to improve the site so it better serves your needs. Join the committee by signing up in the "Members Only" section under "Physicians Lounge" in the "E-mail Lists" area of the TMA site at www.texmed.org. The committee will not meet physically; rather, e-mail list technology will be used to share members' suggestions via e-mail. You can ponder the following issues without ever leaving your home or office:

- New topics for discussion groups on the Web site.
- Usefulness of the site's legislative section throughout the course of a legislative session.
- Features you appreciate or admire on other Web sites.
- Difficulties you may have experienced in finding information on the TMA Web site.

MedBytes is a quick look at new, or newly discovered, Web sites of interest to Texas physicians. The column also highlights features of the TMA Web site at www.texmed.org. If you know of some cool medical sites or have questions about how to use the TMA Web site, e-mail johanna_f@texmed.org. Publication of information about Web sites in this column is not to be considered an endorsement or approval by the Texas Medical Association of the sites or sponsors, or of any products or services involved.

Texas Coalition on Cardiovascular Disease and Stroke cochairs George Rodgers, MD, center, and Clyde Yancy, MD, spoke to the Capitol press corps during a news conference in February on the devastating impact of cardiovascular disease. Rep Diane White Delisi (R-Temple), second from right, along with Sen Jane Nelson (R-Flower Mound) announced the filing of House Bill 1311 (Senate Bill 552), which would create the Council on Cardiovascular Disease and Stroke, an advisory council to the Texas Department of Health.

TMA loan program hits $1 million mark

The Texas Medical Association will provide financial assistance to more medical students than ever before as the TMA Student Loan Program surpassed the $1 million milestone in available funds this year.

Since 1952, TMA's loan program has offered low-interest loans to qualified medical students from several loan funds including:

- The **Dr. S.E. Thompson Scholarship Loan Fund,** which allows students attending The University of Texas System medical schools to apply for a maximum of $3,000 each.
- The **May Owen Irrevocable Trust Loan Fund** and the **Texas Medical Association Alliance Student Loan Fund,** from which students attending Texas medical schools may apply for a maximum of $4,000 each.
- The **Texas Medical Association Special Funds Foundation Medical Student Loan Fund** and the **Texas Medical Association Special Funds Foundation Durham Student Loan Fund,** from which students who are Texas residents attending Texas medical schools may apply for $4,000 per year up to a maximum of $8,000 each.

Students begin repaying the loans 4 years after they graduate from medical school at the interest rate determined by TMA's loan program. Currently, that rate is 4.4%. The Dr. S.E. Thompson Scholarship Loan Fund also is available to residents, who begin repaying the loan 2 years after the loan is issued.

Students may apply for TMA loans through their medical school financial aid offices. A student loan applicant must obtain the recommendation of his or her medical school's financial aid office and a signed promissory note, as well as complete the loan program's application and an interview with a TMA interviewing trustee or a physician who volunteers time to review loan applicants.

Several of the TMA Student Loan Program's interviewing trustees also have reached milestones as far as the years of service they have given to the program. These TMA loan program trustees will be honored for their dedication by the TMA Board of Trustees on Friday, May 7, at the morning session of the TMA House of Delegates at TexMed '99 in Dallas:

- Paul J. Cunningham, MD, Galveston, 25 years;
- S. Perry Post, MD, San Antonio, 19 years;
- Byron L. Howard, MD, Dallas, 17 years;
- Leonard E. Lawrence, MD, San Antonio, 17 years;
- John McNew, MD, Bryan, 17 years;
- Betty P. Stephenson, MD, Sugar Land, 17 years;
- James F. Kirk, MD, Lubbock, 16 years; and
- Elgin W. Ware, Jr, MD, Dallas, 15 years.

For more information on the TMA Student Loan Program, call Sharon Gifford at (800) 880-1300, ext 2828, or (512) 370-1470; or e-mail sharon_g@texmed.org. ★

BEFORE YOU SIGN

Contract TIPS

Things you need to know

Austin attorney mediator Andre Hampton, JD, and the TMA Office of the General Counsel suggest that an ideal managed care contract should:

- **Provide you with the right to reject any new groups of patients or alternate fee arrangements without terminating your right to provide services to existing patients or groups under the contract.**
- **Not contain provisions that require you to significantly alter your practice (for example, with respect to your availability, referral practices, or staffing) or alter the standard of care to which you are held.**
- **Give descriptions of any capitation, risk-sharing, or withhold arrangements the contract provides for or contemplates. The descriptions should be sufficiently clear and detailed to allow you to evaluate fully the risks you are accepting. It also should state that the managed care organization certifies that it has obtained a legal opinion that the arrangements do not violate any law prohibiting incentives to limit medically necessary services.**

Source: TMA Physician Services. For more information or to request a catalog, call (800) 523-8776, or (512) 370-1418; or e-mail physician_services@texmed.org.

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HotLines

TMA switchboard (800) 880-1300

Impaired physicians (800) 880-1640
Call this 24-hour hotline to report information concerning physicians who may be abusing alcohol or other drugs, or who may be chemically addicted, psychiatrically impaired, or have other problems. All calls are confidential.

Insurance (800) 880-8181
The Texas Medical Association Insurance Trust offers life, health, disability, office overhead, personal accident, and other insurance plans and products to TMA members, their families, and office staffs.

Loans (800) 880-2828
TMA offers qualified medical students and residents low-interest loans. Call for general requirements and application procedures.

TEXPAC (800) 880-1300, ext 1362
The TMA Political Action Committee speaks on behalf of physicians through grassroots involvement, personal relationships with elected officials, and political campaign participation and contributions.

TMA Physician Services (800) 523-8776
TMA Physician Services delivers physicians and physician organizations an array of products and services to help them succeed in the changing medical marketplace.

Use the following prefixes plus @texmed.org to e-mail for TMA resources.

General Information	info
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Sneak Preview	sneakpreview
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TMA thanks educational sponsors

The Texas Medical Association recognizes companies and groups that provide educational grants to the association for TMA's annual meeting, TexMed '99: Educational Showcase & Expo, which will be held May 6-9 in Dallas.

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Knoll Pharmaceuticals, Mt Olive, NJ
Wyeth-Ayerst Laboratories, Philadelphia

Bronze
American Cancer Society, Texas Division, Austin
SmithKline Beecham Pharmaceuticals, Philadelphia

Copper
Central Imaging of Arlington, Arlington
Health Integration Technologies, Dallas
Medicheck Services, Inc, Los Angeles

TMA acknowledges, with appreciation, grants from the Charles A. Durham Memorial Lecture Fund, of Houston, and the American Botanical Council, of Austin, which were used to partially underwrite educational programs. ★

POEP Tobacco Project receives more funding

Texas Medical Association's Physician Oncology Education Program (POEP) recently received nearly $12,000 in additional funds from the Texas Cancer Council to expand tobacco cessation training provided through the POEP Tobacco Project. POEP will use the money to reach more providers through upcoming programs produced by HealthNet and Putting Prevention Into Practice (PPIP), an initiative of the US Department of Health and Human Services.

HealthNet, the distance learning network of Texas Tech University Health Sciences Center, will broadcast a live tobacco cessation program from 3 pm to 5 pm on Wednesday, May 5. It will feature Texas experts discussing the impact of clinicians on the tobacco problem and tobacco counseling for adolescents and adults. Physicians, physician assistants, nurses, and respiratory therapists will be able to receive credit through the program aired by HealthNet, which broadcasts to more than 200 sites in the United States, 85 of which are predominantly rural sites in Texas. HealthNet network members may call (800) 424-4888, ext 251, to receive the program.

The POEP Tobacco Project Planning Committee will join Blue Cross Blue Shield (BCBS) of Texas and PPIP to provide technical tobacco prevention and cessation assistance on Friday, May 7, from 10 am to 2 pm, at the BCBS training facility in Dallas. For more information on PPIP initiatives, call Pam Mathison or Patsy Harper at the Texas Department of Health (TDH) at (512) 458-7534.

The POEP Tobacco Project was created when POEP collaborated with BCBS in 1997 to emphasize the importance of physician intervention with every patient who uses tobacco. Studies of medical practices show physicians face barriers such as lack of education, time, and reimbursement when counseling patients on tobacco. Other POEP Tobacco Project participants include the Nurse Oncology Education Program, the Dental Oncology Education Program, TDH, and the American Cancer Society, Texas Division. ★

POEP symposium helps eliminate cancer pain

A Texas Medical Association Physician Oncology Education Program (POEP) symposium offers physicians tools to ease the pain of their patients who are battling cancer.

The symposium, "Eliminating Cancer Pain in the 21st Century: What Clinicians Need to Know," will be held from 7:30 am to 4:15 pm on Saturday, June 19, at the Austin North Hilton & Towers. It will examine current and future trends in the treatment of malignant pain, review current legislative and regulatory control issues related to the use of opioids in managing cancer pain, and describe the influence of different cultures on pain management. Attendees also will explore the role of organizational commitment in establishing an environment that supports pain management and identify interventions that health care providers can use to improve pain management in end-of-life care.

The symposium, sponsored by TMA's POEP, the American Cancer Society, and the Nurse Oncology Education Program, provides 7 hours of Category 1 AMA PRA continuing medical education for physicians, 7 contact hours for nurses, and 0.6 of a continuing education unit for social workers. To register for the symposium or for more information, call the American Cancer Society at (214) 819-1200. ★

TIPS ON HOW TO PUT YOUR PATIENTS FIRST

BEST Practices

Texas Medicine **recently received the following anonymous tips from our readers on how to improve the patient-physician relationship.**

- **Ask patients what would be convenient or best for them — not what the health maintenance organization, preferred provider organization, or insurance company says. Let the patients know they do have choices and some control. They are the consumers; therefore, in a consumer market, they should have some say. Tell them to speak up, and be the resource for complaint/compliment phone numbers.**
- **Encourage hospitals (emergency departments, treatment units, etc) and physicians to report to the Board of Insurance all instances when managed care organizations do not provide the services they have contracted to provide (specialist consultations, clearances for procedures, exams, etc) in the time frames they are obligated by Texas law and their contracts to do so.**

Please send your suggestions for putting patients first and improving patient-physician communication to president@texmed.org.

Forum On Ethics

Group practice, medical records, and the patients

By Stefan G. Sarre, MD, TMA Board of Councilors

The Texas Medical Association legal staff receives many inquiries on the subject of patient records in a group practice and what to do with them when the treating physician leaves the group. This topic has been addressed by both the TMA Board of Councilors and the American Medical Association Council on Ethical and Judicial Affairs. The following is a review of the subject.

There are ethical, legal, and practical considerations. Ethical considerations, though related to morality, are distinct from the purely moral ones. In this case, ethical considerations do not deal with the objectively right or wrong, but with ethical principles promulgated by professional organizations (TMA and AMA). The ethical principles of TMA and AMA make it clear that the good of the patient is the paramount guiding principle.

We need to consider also the legal status of the medical record. The medical record belongs to the one who creates it (the physician, clinic, etc), but the information in it is to be made available to whoever cares for the patient. Both TMA and the Texas State Board of Medical Examiners have made it clear that the physician is obligated to forward patient information when needed, even if the patient still owes him or her money.

Ethical requirements

Because patient care is facilitated by having records available, the records or pertinent information in them must be available when requested. A patient may decide to stay with the group, even though his or her previous doctor leaves. Delivering all the patients' records should be delayed until it is clear which patients actually will follow the doctor to his or her new practice.

We must remember that physicians do not own the patient. The patient can change physicians. In addition, sadly, patients are now forced to change physicians when their insurance carriers change and their physicians are not on the new network.

It also is necessary that the patient be told where his or her physician went. In most cases, the physician leaving a group will publish announcements about his or her new independent practice. If patients inquire of the group, they must be told of the physician's new location; they cannot be told simply that the physician is no longer there.

The TMA Board of Councilors opinion of September 1997 states:

> When a physician leaves a group practice, the patients of the departing physician should be given the following notification:
>
> - That the physician is leaving the group.
> - The physician's new address.
> - That patients may have copies of their medical records forwarded to the departing physician at his or her new practice. It is unethical to withhold such information upon the request of a patient.

It is unethical to interfere with the relationship between the departing physician and his or her patients by withholding necessary information, even when there are other physicians remaining in the group who are qualified to render necessary care.

Additionally, the fact that a physician leaves a group practice should not cause any patient to be neglected or abandoned. It is unethical to interfere with the relationship between the departing physician and his or her patients by withholding necessary information, even when there are other physicians remaining in the group who are qualified to render necessary care.

Dr Sarre is a cardiologist in El Paso.

Texas Medicine welcomes comments about issues discussed in the Forum on Ethics. If you would like to comment or submit a column for possible publication, please contact Teri Moran, senior editor, at *Texas Medicine*, 401 W 15th St, Austin, TX 78701; phone (800) 880-1300, ext 1371, or (512) 370-1371; fax (512) 370-1632; or e-mail teri_m@texmed.org. Proposed columns must be no longer than 900 words and written in a case study format.

Legal considerations

It is possible the medical group's contract may try to prevent a departing physician from continuing to see his or her patients. This would not be practical, because patients will go wherever they want to go (especially if their insurance will still pay). Because it is not known which patients will leave the group, it is not practical to give the departing physician the records or summaries of all his or her patients.

However, once a patient requests that his or her records or summaries be forwarded to another physician, this should be done, regardless of contractual provisions. To refuse to forward records would violate the TMA and AMA ethics code, and the physician involved could certainly lodge a complaint with his or her county medical society or appeal to the TMA Board of Councilors.

What if the physician has signed a contract not to compete within the geographic area? The group can pursue that matter in court, but meanwhile, patient care must not be interfered with by withholding records.

A group unlikely would be willing to face the bad publicity of going against the TMA ethics code and being perceived as interfering with continued patient care. A contract that precludes forwarding of records probably would be held unenforceable because of conflict with the public interest (good patient care).

Conclusion

If a physician leaves a group practice, the group is obligated to inform his or her patients, upon request, of his new address. Likewise, records or summaries must be transferred to the new physician upon receiving individual requests. Physicians experiencing problems with this should contact their county medical society or the TMA Board of Councilors. ★

SUMMARIES OF RECENT HEALTH CARE HEADLINES

In Case You Missed It

By Melissa McEver

Scientists have discovered a surprising link between a sexually transmitted infection and heart disease. Researchers at the UNIVERSITY OF CALIFORNIA-IRVINE found that mice infected by *Chlamydia trachomatis*, a bacteria commonly spread sexually, developed heart disease when the immune system attacked muscle cells in the heart. A heart muscle protein is almost identical to a protein on the bacteria's surface. The scientists concluded that more research needed to be done on the chlamydia-heart disease connection. (*Science*, 2/26/99)

Preventing HIV infection can start at the community level, a recent study found. A report sponsored by the CENTERS FOR DISEASE CONTROL AND PREVENTION concluded that community HIV prevention programs in five cities, including Dallas, made a significant impact in preventing HIV risk behaviors through distributing role-model stories, bleach, and condoms to high-risk populations. The researchers said the study provides evidence that outreach programs by peer groups can reduce HIV risk behavior. (*American Journal of Public Health*, 3/1/99)

Yearly stool screening reduces colon cancer deaths by a third, a new study has found. Dr Jack Mandel and others at the UNIVERSITY OF MINNESOTA AT MINNEAPOLIS assigned more than 46,000 patients to fecal occult blood screenings beginning in 1976 and 1977 either biennually or annually, with some of these patients receiving no screenings. They found that colorectal cancer deaths were 33% lower in the annual screening group than in the unscreened group and 27% lower in the biennual group. (*Journal of the National Cancer Institute*, 3/3/99)

A new report has revealed that abnormal mammogram findings can result in long-term distress for women even if a second mammogram proves normal. Dr John B. Lowe and other researchers at the UNIVERSITY OF QUEENSLAND in Herston, Australia, found through interviews with nearly 400 women that those who were recalled for second mammograms experienced more long-term worries about cancer and more emotional distress in general than those women whose first mammograms were normal. The scientists recommended that physicians inform their patients that most women who are recalled do not have cancer. (*Cancer*, 3/1/99)

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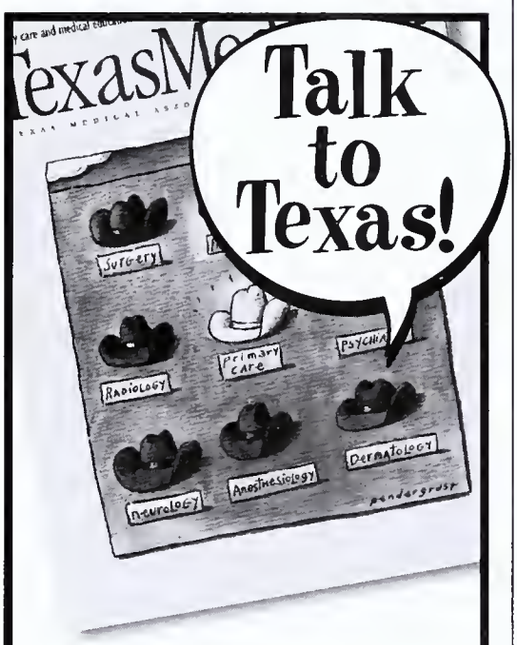

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Working poor parents lack health insurance

Working poor parents are twice as likely to be uninsured as poor parents who are unemployed, according to a study by the Center on Budget and Policy Priorities released in February.

The findings of the report, "Employed but Not Insured: A State-by-State Analysis of the Number of Low-Income Working Parents Who Lack Health Insurance," are based on US Census data and provide, for the first time, information on the percentage of low-income working parents in each state who lack insurance. Some of these findings include:

- About 46% of the 4.9 million working parents with incomes below the federal poverty line — $13,650 for a family of three — were uninsured in 1997.
- More than one of every three parents with incomes below 200% of the poverty line — $27,300 for a family of three — lacked insurance in 1997.
- In nine states — Alabama, Arkansas, Florida, Idaho, Indiana, Louisiana, Texas, Virginia, and West Virginia — parents cannot qualify for Medicaid if their earnings are above 37% of the poverty line, or $5,050 for a family of three. ★

UT Southwestern creates stroke research chair

With a $250,000 pledge from a former Dallas County Hospital Board member and his wife, The University of Texas Southwestern Medical School in Dallas will establish the Earl A. Forsythe and Janet Kendall Forsythe Chair in stroke research.

The Forsythes have indicated they will double their pledge in the future, which ultimately will create a $1 million distinguished chair with matching funds from the Southwestern Medical Foundation. ★

What's in a name?

Texas Medical Association's Texas Physician Services Organization (TPSO) has changed its name to TMA Physician Services to better reflect its unity with TMA and its expanded menu of services.

"With a new name and even more to offer, TMA Physician Services can help Texas physicians better navigate through the turbulence that increasingly disrupts the business side of today's medical practices," said TMA Executive Vice President Louis J. Goodman, PhD.

Texas Medical Association **Physician Services**

Since 1995, TPSO has provided physicians across the state with products and services to assist them with the business aspects of medicine. From solo practitioners in rural Texas to large networks in urban areas, TPSO has helped physicians develop managed care strategies, find consultants, or gather data to monitor payments and help negotiate managed care contracts.

TMA Physician Services will deepen this commitment by helping physicians implement managed care strategies as well as providing assistance with practice management; starting, selling, closing, or merging a medical practice; marketing; and managed care contract analysis. Additionally, TMA Physician Services can facilitate access to managed services organizations that provide data management to help monitor claims payments, third-party administration, credentialing, provider-specific stop-loss coverage, risk management programs, and insurance products.

Call TMA Physician Services at (800) 523-8776 to order a free catalog of services, or visit the "TMA Physician Services" area of the "Business of Medicine" section of TMA's Web site at www.texmed.org. ★

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DR. NANCY DAMBRO — MEDICAL DIRECTOR OF PEDIATRIC PULMONOLOGY

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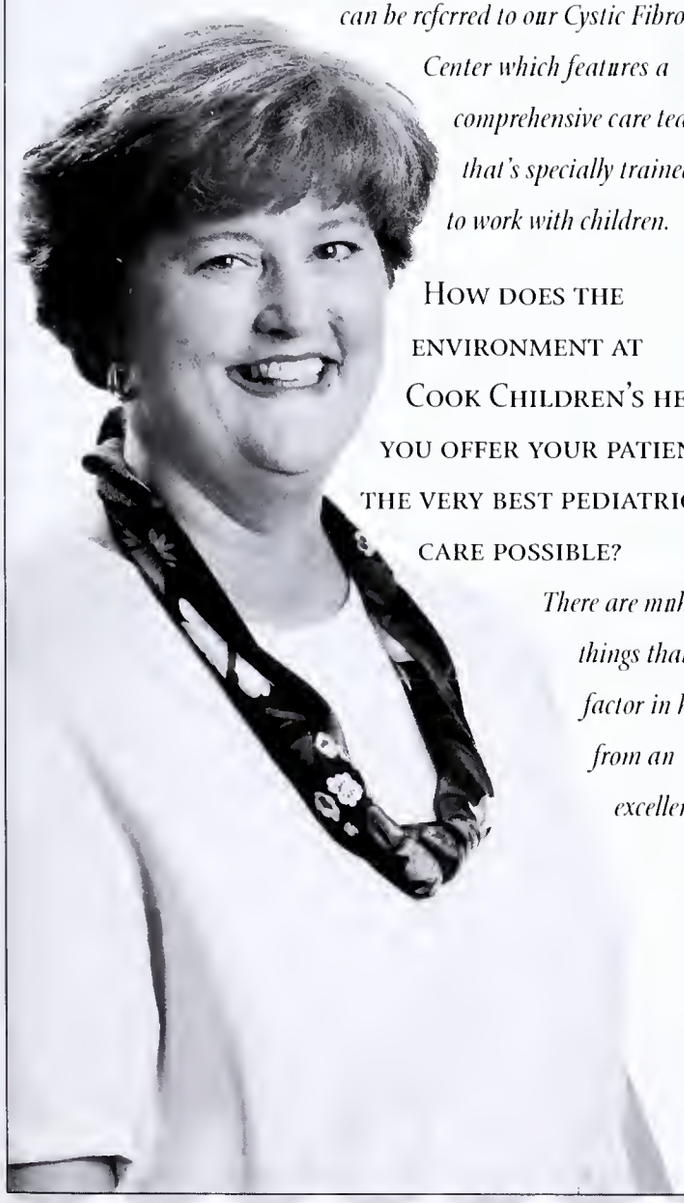

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DR. DAMBRO, WHAT TRENDS ARE YOU WITNESSING IN PEDIATRIC PULMONARY CARE, AND HOW IS THIS IMPACTING TREATMENT MODALITIES?

First, the morbidity rate of asthma has gone up in developed countries, so the anticipatory preventative care of asthma has become critical. Second, in the area of cystic fibrosis, there is a plethora of new medicines helping patients live longer, and this is challenging physicians to keep treatment on the cutting edge.

Cook Children's Medical Center is located in Fort Worth, Texas. For more information about Dr. Dambro and our other doctors of Pulmonology — James Cunningham, Maynard Dyson, Sami Hadeed and John Pfaff, call 1-800-COOK517.

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Standing on shaky ground

Texas has allowed insolvent HMOs to stay in business

Regan Dunnick

Talk about bad luck and lightning striking the same place twice. In an alarming double whammy, many San Antonio physicians were first hit by FPA Medical Management's bankruptcy last year, and then shortly afterward, they and some 17,000 patients were slammed by the failure of WellChoice, a San Antonio-based health maintenance organization (HMO).

"Hundreds of physicians and their patients watched things crumbling around them and thought, 'What next?'" said Dennis Dawson, executive director of the Bexar County Medical Society. ➤➤

By Teri Moran, Senior editor

The failure of WellChoice demonstrated the worst that can happen when HMOs are allowed to operate in the red and with insufficient capital in reserves.

Texas is one of the few states that doesn't require HMOs to set aside assets to support all their liabilities and allows them to operate in an insolvent position. However, at press time, a bill that would force the industry to maintain adequate reserves was working its way through the Texas Legislature.

Natural consequences

To gain market share, HMOs across the country have been underbidding their services with rock-bottom premiums, says Teresa Devine, Texas Medical Association's director of health care financing. "Although we've only had one failure [WellChoice] so far in Texas, the HMO industry in this state has not made a profit since 1996. Some individual plans have made profits, but even several of the largest plans, such as PruCare, Aetna, and NYLCare, have suffered losses."

And the industry is losing money even while it adds enrollees faster than ever, according to *Texas Managed Care Review,* a report by Allan Baumgarten, JD, a Minneapolis researcher and health care consultant. Texas HMOs lost $97.5 million, or 2.8% of revenues, in the first 6 months of 1998, Mr Baumgarten's report shows. In 1997, the picture was even worse. That year, they lost money at an even faster rate — $232.9 million, or 4.1% of revenues.

"Texas HMOs don't have much of a financial cushion to fall back on," Mr Baumgarten said. "At the end of 1997, they had an average net worth equal to only one half-month of operating expenses — less than in any other state."

Enrollment in Texas' 51 HMOs has increased to nearly 20% of the population, or 3.7 million Texans.

But when HMOs gobble market share at the expense of healthy balance sheets, its enrollees and providers ultimately pay the price, as was the case with WellChoice. When WellChoice began getting slower and slower in making physicians' payments, Mr Dawson notified officials at the Texas Department of Insurance (TDI). A few months later, TDI declared WellChoice insolvent and placed it into receivership. "There's no early warning system from the state about possible HMO failures," Mr Dawson said. "And when one does fail, there's no guarantee fund to protect patients. We had so many patients caught between a rock and a hard place. They were calling us for help in keeping continuity of care."

PacifiCare of Texas, Inc, agreed to provide coverage to the 17,000 patients left hanging, but it did not assume WellChoice's provider contracts.

"There's no early warning system from the state about possible HMO failures. And when one does fail, there's no guarantee fund to protect patients."

Health care concerns, including HMOs, provider groups, and physician practice management companies, are failing all over the country in a shake-up many industry experts are calling a crisis that could reshape health care.

In California this March, the state seized MedPartners Provider Network Inc, a network of 1,000 physicians who cared for 1.3 million Californians. Also in March, a New Jersey judge dissolved HIP Health Plan of New Jersey, the state's oldest and fourth largest HMO, which had some 82,000 members. Health care organizations in Florida, Arizona, Maryland, and Mississippi have either gone bankrupt or been seized by state regulators.

Establishing control

Thanks in part to the failure of WellChoice, TDI developed a legislative package to address HMO insolvency, which, at press time, was in committee. Describing the need for the bill, Texas Commissioner of Insurance José Montemayor said the HMO industry's operating losses amounted to approximately twice its current net worth during the 2½-year period ending in mid-1998. "This is a rather thinly capitalized industry," Mr Montemayor said. "I'd like to see more underlying strength in the HMO industry in general — more of a safety net in terms of the surplus available."

House Bill 3023, sponsored by Rep John Smithee (R-Amarillo) will make a few significant changes in how HMOs must manage their books. The bill requires HMOs to show all their liabilities when calculating their net worth, and allows TDI to develop a capital net-worth requirement for HMOs based on the level of risk they assume. HMOs that assume more risk will be required to have more capital.

"We are in favor of more stringent solvency and financial reserve requirements," said Jerry Patterson, executive director of the Texas Association of Health Plans. "It may be a problem for smaller HMOs, but the bill allows for incremental implementation. I don't think anyone will have an immediate problem as long as that stays in the bill."

The bill has a good chance of success because TDI officials put a lot of time and effort into working with the HMO industry before delivering legislative recommendations, says Susan Night, TMA's director of health care delivery. "TDI officials wanted to make sure they understood the bill's impact on the industry beforehand, and they were able to get the industry's support."

Although it may be overdue, the bill will go far in protecting HMO enrollees and their physicians, Ms Night says. "Hopefully, it will keep HMOs from biting off more than they can chew and prevent disasters like WellChoice."

Merging for survival and dominance

Merger mania has been raging across the country. A few examples that have affected Texas include New York Life's purchase of Sanus to form NYLCare, Humana buying PCA, and Aetna buying NYLCare. Now, two larger mergers are in the works — Harris Methodist Health Plan with Blue Cross Blue Shield, and Aetna with Prudential.

The proposed merger of Aetna and Prudential would create the largest

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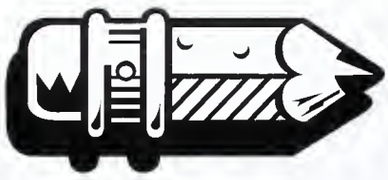

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health insurer in the country, raising the total number of Aetna enrollees to 22.4 million. At press time, the US Department of Justice had not yet approved the merger because it raises antitrust issues, nor had TDI approved the merger in Texas.

The impact of all these mergers varies by metropolitan area, Ms Night says, with the proposed Aetna/Prudential merger having the most overall. "Statewide, the Aetna/Prudential deal could result in it having a combined market share of more than 40% in some Texas markets. More importantly, it will reduce the choices of HMO options for people in several metropolitan areas."

In Austin, Ms Night says, Aetna would control 27% of the market, leaving just four health plans that command 98% of the area. In Dallas/Fort Worth, Houston, and San Antonio, Aetna's control would reach up to 50% or more of the market. "This puts health care into fewer and fewer hands, reducing competition and patient choice."

Many experts have the legitimate fear of what such market dominance tends to allow — the ability not only to set price but to control almost every aspect of the business. Ms Devine points to Houston as an example. "If and when Aetna buys Prudential, it will have between 50% and 55% of the market. And while HMOs are in the process of buying market share and merging companies, they can keep premiums pretty low. But after they have it all in place and rule the market, they can do pretty much what they please."

Ms Devine ascribes some of the fallout lately to simple market maturation in Texas, comparing it with California, which has had managed care longer. "Texas has 51 HMOs with close to 3 million enrollees. But California has 10 times the number of enrollees and only about 30 HMOs."

If Aetna is successful in merging with Prudential, it probably will accelerate the maturation process in Texas, Ms Devine says. "For the remaining HMOs to compete, they're going to have to do the same thing. They're going to have to get bigger, and that will mean more mergers and acquisitions."

Curiously, the parent companies of many Texas HMOs have so much money that they can afford to lose it year after year in one state, Ms Night says. "Their corporate pockets are so deep, the parent company can subsidize the losses of an HMO in a single market while it garners market share."

The corporate parents of WellChoice refused to bail it out, resulting in its failure. The top six HMOs in Texas, which enroll the vast majority of HMO subscribers, have national corporate sponsorship. Most of the rest are hospital-based HMOs that have fewer than 10,000 subscribers.

As a relatively recent arrival on the Texas landscape, HMOs have grown faster than state government can keep up with them. TMA has been involved actively in the regulatory scramble to catch up by pushing patient protection bills through the state legislature. And by pushing Texas to the forefront, TMA is forcing the issue onto the national agenda in Congress.

TMA keeps close relationships with HMOs in the state through its Medical Directors' Forum, which allows TMA leaders to meet regularly with HMO medical directors, many of whom also are TMA members. Through TMA's Corporate Advisory Committee, TMA maintains dialogue with chief executive officers of Texas HMOs.

In time, the Texas HMO landscape likely will look more like that of California, with fewer HMOs controlling more of the market, experts say. It could one day even resemble that of Minnesota, where three HMOs control 80% of the market. Until then, expect more mergers, Ms Night says.

She recommends that physicians evaluate carefully their HMO contracts, "and also find out whether the company is healthy before you sign on." For HMO profiles, see the TDI Web site at www.tdi.state.tx.us/company/hmo/alpha. html. ★

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Cyberspace medicine

Physicians are going online for their patients

by Laurie Stoneham

The patient has an allergy to latex. So, Richard Levy, MD, leaves the exam room and downloads a couple of articles from the Internet to give the patient before the visit is over.

That evening at home, Dr Levy spends 15 to 30 minutes answering e-mails from patients about such things as impingement syndrome and prescription refills.

A physician from a third-world country may have a question about cartilage transplants or some other cutting-edge procedure. Dr Levy, an orthopedic surgeon in Dallas, shares what he knows electronically with a colleague he'll probably never meet.

Then he might do a MEDLINE search for the latest articles relating to his expertise in shoulder surgery before calling it a day.

An incredible communications tool

This is the only way Dr Levy has ever known to practice medicine. Sure, he's young. Only in practice since 1996, he knows it's an extremely efficient way to communicate with patients and stay on top of his specialty.

"The reason we go into medicine is to be able to help people and to disseminate information on our specialty," Dr Levy said. "The Internet gives us a powerful outlet for doing just that."

So it was only natural that Dr Levy would use his computer programming experience to set up a World Wide Web site for his group, Texas Sports Medicine. People logging onto www.txsportsmed.com learn about the three specialists in the group, the staff, what services are provided, and the office locations, hours, and telephone numbers. New patients can request appointments and download registration forms that can be filled out before going into the office. There's an area where guests can go to discuss their experiences. Then folks can ask the doctors anything relating to sports medicine. The group's office manager routes these questions to the appropriate doctor who responds via e-mail.

The founding partner of Texas Sports Medicine, Tarek O. Souryal, MD, says a few years ago he was intimidated by the technology. "I barely knew how to turn my computer on. But to be honest with you, I'm a true convert. I can't go without checking my e-mail every 3 to 4 hours," Dr Souryal admitted.

The group has grown significantly since 1996. While they can't quantify what portion of the growth can be attributed to the Web site, both physicians say it has been the referral source for a number of new patients.

Unmatched efficiency

Russell Roby, MD, an allergist in Austin, knows more precisely. His Web site at www.sig.net/~allergy has been up since 1995, and he says it has increased his practice gross by 20% to 30%.

His interest developed from being frustrated at the difficulty in getting through to people by phone. And "snail mail" responses would take weeks or months, if they arrived at all. E-mail was different. He could get through in minutes. "I've had major researchers from all around the world respond to my inquiries almost immediately. Once Bill Gates replied to some e-mail I sent him in 2 hours. I am very impressed with the efficiency of electronic communication."

Today, Dr Roby spends an hour or so a day answering e-mails from patients and nonpatients. They may have learned from his Web site that what they thought was a cold is in fact allergies, or they may want to know more about his specialty — food and hormonal allergies.

Research No. 1

Texas Medical Association and American Medical Association polls find that, after e-mail, physicians are using the Internet most for medical research, according to Steve Levine, director of TMA's Division of Communication.

Texas physicians are conducting PubMeb and MEDLINE searches, says Nancy Reynolds, director of the TMA Library. "While performing their online searches, physicians can select, mark, and order full-text versions of the articles they find, and these orders are transmitted electronically to the TMA Library," Ms Reynolds explained. She adds that the TMA Library is one of the nation's largest participants in the National Library of Medicine's Loansome Doc retrieval program. The cost for members is $5 for up to 10 articles, plus 10 cents a page for photocopying.

Other uses

J. Colton Bradshaw, MD, a pediatrician in Mount Pleasant, characterizes himself as a novice on the Internet, even though he has two Web sites. One was developed free of charge through Physicians Online and the other by Zeneca Pharmaceutical. His 3 hours a week of Web surfing include e-mailing his family in Louisiana, tracking Utah Jazz statistics and stories, and conducting medical research.

"However, communication with other pediatricians in subspecialties already has begun to occur, which is quite an asset to my very rural private practice in general pediatrics," Dr Bradshaw said. "I have hopes of obtaining some CME credits via the 'Net, since most good conferences are far away and expensive for me to attend."

He can do that by visiting TMA's Web site. There he will

find several online continuing medical education (CME) courses, including one that satisfies the ethics requirement for license renewal. A listing of other CME courses throughout the state also is available.

"I've had major researchers from all around the world respond to my inquiries almost immediately. Once Bill Gates replied to some e-mail I sent him in 2 hours. I am very impressed with the efficiency of electronic communication."

Cyber pioneer

Philip Suarez, MD, is so convinced that the Internet is the most important communications tool of this century that he founded Internet Connect Services, Inc, an Internet service provider, in 1994. The Victoria obstetrician says at first he felt like Don Quixote tilting at windmills, because at the time most people looked at him with glazed eyes and asked, "What's the Internet?"

His intention was to make www.icsi.net a physician-centered service, but today, medical users make up only a fraction of the several thousand subscribers. Dr Suarez finds that somewhat disappointing. "Physicians are the last educated group of people to use the Internet," he said.

While undoubtedly some physicians are optimizing the current potential of the Internet, only 2% to 3% are using it for patient e-mail. Dr Suarez believes two factors account for the reticence of his colleagues as a whole. "First, they are time leveraged and aren't convinced that their time investment in learning to use it will pay for itself. Second, they aren't sure whether this is a fad or a toy of some kind. They can't visualize the jump from a toy to a tool, a very efficient tool."

TMA Advantage:
For members only on the Web

One goal of the TMA Web site — www.texmed.org — is to put you within easy clicking of a wealth of information. Therefore, more value has been transferred to the "Members Only" section of your Web site. Here's what you'll find:

TMA PHYSICIAN SERVICES (FORMERLY TPSO) MANAGED CARE CONTRACTING BOOKLETS
Before You Sign on the Dotted Line ...
Managed Care Model Contract
Managed Care Contract Checklist

TMA PHYSICIAN SERVICES QUALITY INITIATIVES
Quality Management Plan for Physician Groups and Networks
Physician Office NCQA Checklist

MEDICARE
E & M Service Distribution Report

PAYMENT ADVOCACY
Model provider participation agreement

LEGISLATIVE
Legislative Hotline Daily
Legislative Hotline Weekly Replay
Political Prognosis for 1999
Legislative Preview

E-MAIL LISTS
***Action* via e-mail**
Legislative Hotline Daily
Legislative Hotline Weekly Replay
Virtual Advisory Committee

NEWS AND EVENTS
Texas Medicine
Action

PHYSICIANS LOUNGE
Find a Member, including e-mail addresses
Update personal information
Discussion group for the Texas delegation to the AMA
Open forum on professionalism, quality, and ethics
Physician health and rehabilitation information (5 CME courses and 10 brochures)
Summary of actions taken by the House of Delegates
House of Delegates transactions
Interim report on 1998-1999 TMA Strategic Plan

PRESIDENT'S PAGE
Results of the member participation survey

CYBER SWEEPSTAKES CONTEST
Quarterly contest for members

YEAR 2000
AMA's *Year 2000 Problem: Guidelines for Protecting Your Patients and Practice* manual
TMA Physician Services Y2K checklist

Tom Ferguson, MD, a professor of health informatics at The University of Texas-Houston Health Science Center and author of *Health Online*, thinks physicians can't afford to ignore their patients' use of the Internet any longer. He sees the trend toward patients using online health resources as a consumer-driven revolution that will have a substantial impact on medicine. Dr Ferguson thinks it's incumbent upon physicians to understand this coming shift, to begin communicating with patients online, and to participate in planning other future online services.

"I don't know if they've gotten it from *The New England Journal of Medicine* or the *Drudge Report*. People think just because information is on the Internet, it's true, and there are a lot of inaccuracies out there. This can cause trouble when people start trying to diagnose themselves."

Consumer revolution

According to a Harris poll conducted in January, 44% of all Americans have access to the Internet, and of those, some 60 million adults used it last year to find information about health care.

More than 25,000 Internet sites address every health condition known to man. Some of the information is valuable; some of it is hogwash. And now, along with all their other responsibilities, physicians are being asked to comment or elaborate on the information their more-knowledgeable-than-ever patients have dug up from the Internet.

That's disturbing to Peter Killinger, MD, a pediatrician in Houston. "I don't know if they've gotten it from *The New England Journal of Medicine* or the *Drudge Report*. People think just because information is on the Internet, it's true, and there are a lot of inaccuracies out there." Just as troubling for Dr Killinger is the way patients are using it for self-care. "This can cause trouble when people start trying to diagnose themselves."

To aid the research efforts of both consumers and physicians, TMA's Council on Public Health has helped to create a 14-category gateway on the TMA Web site (www.texmed.org) that provides links to trusted sources of health information such as the Mayo Clinic, HealthOasis, and the National Institutes of Health Web site of consumer health resources.

Empowered patients

Dr Ferguson, author of a dozen books on consumer health, and editor and publisher of the free e-mail newsletter *The Ferguson Report: The Newsletter for Consumer Health Informatics* (available by e-mailing join-ferguson-report@sparklist.com), believes the Internet is helping to create a new type of player for the health care team — the well-informed online patient. Information gathered from online sources is empowering what he calls these "smart patients" with a new understanding of their conditions. In some cases, he says, patients are coming into doctors' offices knowing more about some aspects of their diseases and treatments than their physicians do.

Dr Ferguson believes it's in physicians' best interest to welcome and encourage these smart patients, to gently correct

So you want to be on the Web, eh?

Putting a Web site together is easier than you think, according to Kirk Wilson, president of Bazzirk, Inc (www.bazzirk.com), an Austin firm that specializes in cyber marketing. If you're "technically hip" and have a decent eye for design and a do-it-yourself personality, Mr Wilson says, you may enjoy putting up your own Web page. Here's what he suggests:

1. **Determine what you're trying to accomplish. Do you want information about your practice only or do you want something more complex, such as discussion forums and methods for people to ask you questions? If it is fairly straightforward, a number of off-the-shelf software packages can help you design a good-looking page. This software costs about $200.**
2. **Obtain a Web address, or URL (uniform resource locator), as it's called. To check on the availability of an address, go to rs.internic. net/cgi-bin/whois. Then, after you have a clear address, register the address by working with your Internet service provider or directly by going to www.internic.net/help/domain/new-domain-reg.html.**
3. **Publicize your site so people looking for a specialist in your area will find you on the Web. Software is available for this purpose, or you may contract with someone to promote your site.**
4. **If you're creating your own site, don't forget to keep it up to date by periodically providing some "fresh information." That will keep people coming back for more.**
5. **For more technically complex sites, you'll probably want to rely on a Web design firm. Be sure to shop around, though, and learn what a company's capabilities are, what you can expect from initial design, and how much it will cost, including ongoing maintenance.**

them when they are mistaken, to negotiate a mutually acceptable treatment plan, and to work together as colleagues to carry it out. "The best and the brightest of these smart patients spend many hours a week keeping up on their conditions. They can help keep their physicians up to date on new treatments and therapies," he said. "They can save physicians valuable time."

"I can easily foresee a time where you're online with your doctor in your living room, sitting in front of your TV set, and you're talking to one another. You can literally see him and talk to him from your living room and he can prescribe to you and have medicines delivered to you online. That is something that really is not that far off."

Communicating with colleagues

Dr Suarez uses e-mail to communicate with referring physicians. "I'll refer a patient to a specialist in Houston and receive a dictated e-mail report within an hour of her visit. So when she comes back and has questions, I can respond knowledgeably and therefore improve the quality of care I can provide."

He thinks electronic communication is a huge advance in efficiency in health care delivery, and it's the only way he will practice medicine. "Do you think I'm going to refer a patient to a doctor who doesn't use e-mail to communicate with me so efficiently? No way."

Maintaining confidentiality

Communicating in cyberspace is not without its risks, though. "You'd never mail a letter without sealing it first. Well, e-mail is like sending a postcard in cyberspace," Dr Suarez explained. That's why he says it's imperative that all patient communications be encrypted. Several off-the-shelf e-mail software programs are available to provide this protection, but they are technically cumbersome to use, according to Dr Suarez. He suggests a free alternative, Pegasus, which can be downloaded from www.pegasus.usa.com.

Passwords are necessary for encrypted e-mail to be opened and read. Dr Suarez tells colleagues what the password is. For patients, he uses their Social Security numbers. He adds, "It's not up to us to decide what should be treated in a confidential manner. So I encrypt any e-mail that contains a patient's name."

Squashing the Y2K bug

You're probably sick to death of hearing about this Year 2000 (Y2K) computer glitch stuff. But have you done anything about it? A recent study by Gartner Group Inc, found that 64% of US hospitals — the majority of them, small facilities — have no plans to test their Y2K readiness. It also found that 90% of doctors are unaware of how the problem may impact their practices.

The General Accounting Office also predicts snafus with processing of Medicare claims because the Health Care Financing Administration is nowhere near ready for the clocks to turn over. Studies show that the health care industry, including individual physicians, is woefully behind in getting ready for the new century. So, if you haven't already started, here's what you can do to prepare your practice:

1. **Assess what systems contain date-sensitive chips that may read 1/1/00 as 1900 instead of 2000. This would include computer hardware and software and diagnostic or monitoring equipment such as intravenous pumps, heart defibrillators, pacemakers, CT scans, and dialysis equipment. For a list of medical devices that are known not to be Y2K compliant, go to www.rx2000.org. Check building and office equipment, including your telephone and security systems.**
2. **Contact the manufacturers of these systems to learn whether they will operate properly. Obtain as much assurance as possible through testing and checking, certification, or written notification that your systems can continue to correctly process patient records, billing, accounting functions, and payroll.**
3. **Find out the preparedness of critical partners, including service bureaus, billing services, and claims processors, to make sure you have a solid working interface that will allow you to continue to bill and receive payments.**
4. **In general, be as aware and as proactive as possible in diagnosing and treating any potential Y2K bugs that could put the bite on your practice.**

Also, the TMA Web site has links to other important Y2K resources you can access through www.texmed.org/business_medicine/quality_improvement/bm_y2kresources.html.

You also can download the AMA's *Year 2000 Problem: Guidelines for Protecting Your Patients and Practice* manual through the "Members Only" section of www.texmed.org.

Legal issues

What are the legal liabilities of being on the Web? Attorney Brenda Strama, JD, a partner in the health care section at the Vinson and Elkins law firm in Houston, says the laws that apply to traditional practices also apply to any cyber activity. "You're in safe territory by having an information-only Web site," she says. This can include information about yourself, your practice, and authoritative articles relating to your specialty.

"What starts to become risky," Ms Strama continued, "is making representations such as, 'We provide only the highest quality optimal health care,' which raises the standard of care over and above the community standard." This same advice applies to any marketing material, she stresses.

The health care attorney added that if e-mail is used for any type of diagnosis and treatment, "you really ought to consult a lawyer about the individual activities you have in mind."

> "The goal is not to reinvent the wheel, but to use the Web and electronic communication so physicians can optimize the value of their TMA membership."

TMA at the forefront

TMA has maintained its Web site since 1996, and usage has grown dramatically. Mr Levine says the number of unique user sessions has jumped 900%, from 3,000 in June 1997 to almost 30,000 in December 1998.

The organization as a whole is offering more and more services via its Web site to increase efficiency and decrease the costs of doing business, Mr Levine reports. "If we can e-mail something, instead of mailing, faxing, or telephoning, we can save substantial amounts of money."

Today, members can interact with every TMA department electronically and easily take advantage of what Mr Levine calls "our most important commodity — information." (See "For Members Only on the Web," p 39.) "The goal is not to reinvent the wheel," he says, "but to use the Web and electronic communication so physicians can optimize the value of their TMA membership."

Cyber trends

While Texas physicians are approaching the Web in a conventional fashion, so-called "virtual house calls" are taking place at www.CyberDocs.com. Providers diagnose and treat minor emergencies and non-life-threatening conditions. Patients and doctors visit by typing back and forth to each other. Treatment may include a prescription that can be filled by CyberPharmacy (a sister company) and shipped to the patient anywhere in the world within 48 hours.

America Online subscribers can talk to physicians free of charge through the Ask-A-Doctor program. Its parent organization, America's Doctor, Inc, employs nearly 1,000 physicians to answer questions and provide health information over the Internet. No diagnosis or treatment options are available. If necessary and requested, cyber patients are referred to local physicians for traditional hands-on visits.

What's still out there

Where is cyberspace leading medicine? Kirk Wilson, president of Bazzirk, Inc, an Austin-based firm that specializes in Web site design and Internet marketing, thinks that once bandwidth (the amount of data that can be transmitted) issues are resolved, patient-physician interactions will change dramatically. With the evolution of videoconferencing equipment, he said, "I can easily foresee a time where you're online with your doctor in your living room, sitting in front of your TV set, and you're talking to one another. You can literally see him and talk to him from your living room and he can prescribe to you and have medicines delivered to you online. That is something that really is not that far off."

Mr Wilson predicts far-reaching online alliances, what he called "a virtual practice where a specialist in England and a specialist in India and a specialist in Austin are all a part of the same team. I think that will allow doctors to have all kinds of new, exciting partnerships and ways to gain exposure, not only to patients but also for themselves in a business sense."

Mr Levine sees a time when TMA meetings will occur online. "Why spend the time and money to rent a room, bring the people in, serve food, and have the physician miss an entire day of working with his or her patients simply for a 2-hour meeting? Many people 40 and under don't like to go to meetings. We have to find a way to take it to them, and that's what we hope technology can do."

Dr Ferguson said successful health care systems of the next decade "will be those that are the pioneers in finding ways to deliver useful and convenient online services. As more and more of the population goes online, online services will become the marketing battleground for health care." He thinks there will be more e-mailing between doctors and patients and more provider-sponsored Web sites where patients can access information, request refills, schedule appointments, talk to a nurse, submit questions to a physician, and communicate with other patients with the same condition.

For the individual physician, Dr Roby is a bit more blunt. "Any physician who isn't already using the computer and the Internet is probably about ready to retire." ★

Laurie Stoneham is a freelance writer in Austin.

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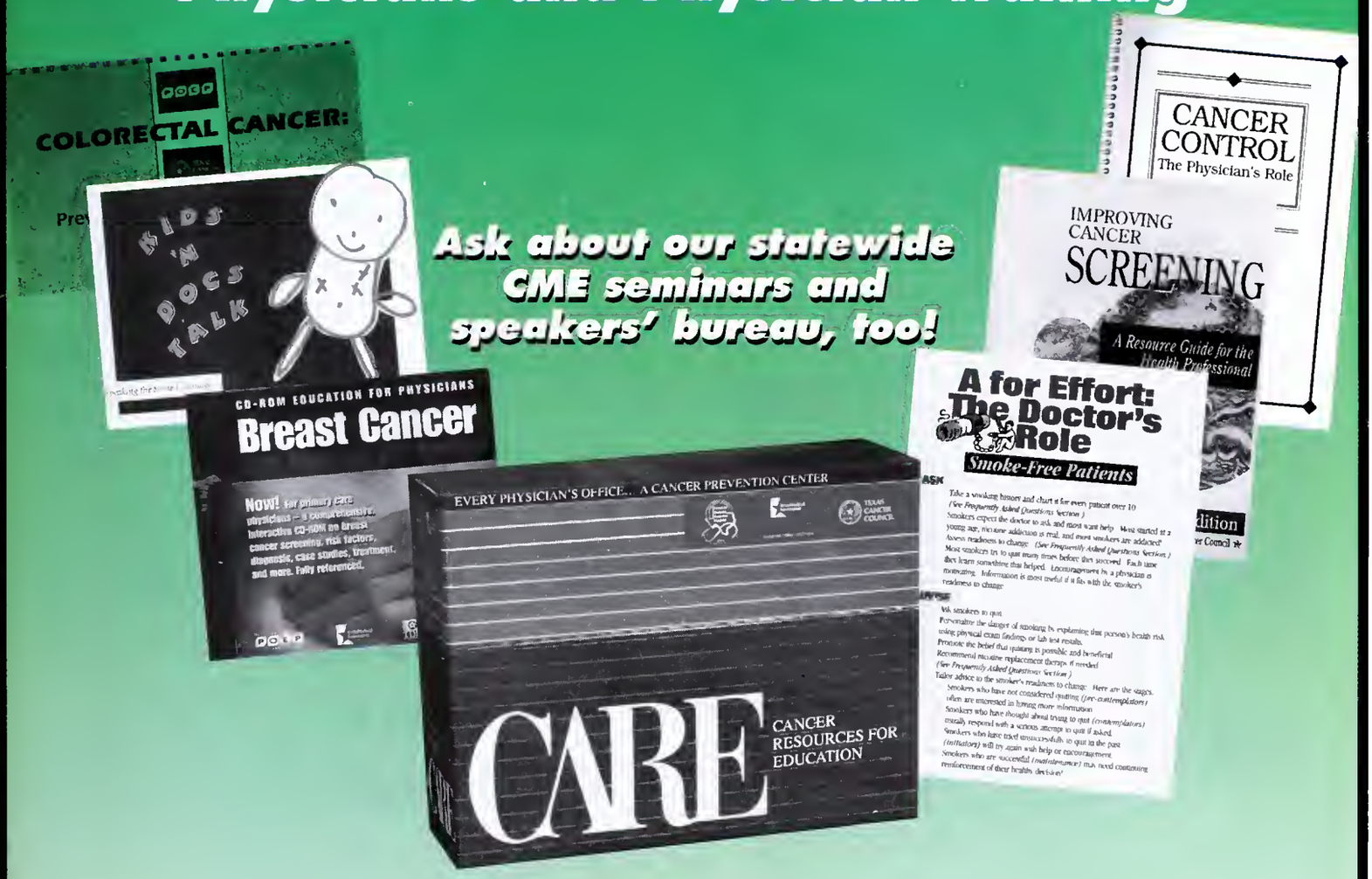

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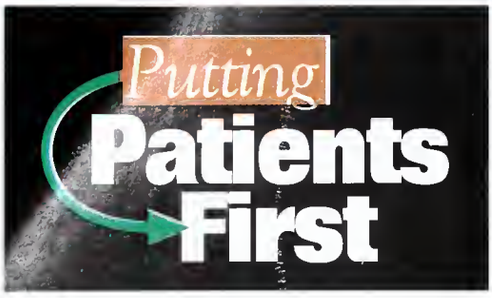
Under one roof

Scott & White's integrated system sets managed care standard

Once called Mudville for its abundant blackland prairie soil, the Central Texas city of Temple can thank railroads and farming for putting it on the map. But it rightly credits its hometown clinic and hospital for giving it a national medical reputation.

Temple seems an unlikely, out-of-the-way place for a vanguard health system to originate, but Scott & White has developed the gold standard of integrated health care delivery. ➤➤

By Teri Moran, Senior editor



Most Texas physicians know Scott & White as one of the largest multispecialty group practices in the United States. But fewer know that long before managed care swept across the nation, Scott & White physicians began to pioneer the whole idea of integrated health care by merging physicians, a hospital, clinics, and health insurance into a single system. And Scott & White has taken integrated health care delivery further than any other system.

Furthermore, in an era when doctors are becoming increasingly concerned about managed care's impact on the way they practice medicine, Scott & White's commitment to keeping physicians in charge of the decision-making shows that not all managed care plans are alike.

Building blocks of integration

The word "integration" in health care has many different definitions, according to pediatrician David Morehead, MD, president of Scott & White's Health Plan. "When Columbia was in its heyday, it described itself as an integrated system because it owned many hospitals and physician groups in different parts of the country. It achieved legal and financial integration. But Scott & White believes that integrating health care should go much further and that it means putting the core elements together — physician practice, the hospital, and the health care financing vehicle — into a system that functions as a single unit."

Scott & White Health Plan, a nonprofit health maintenance organization (HMO) launched in 1982, has now grown to some 165,000 members.

In addition to its Temple location, 17 regional Scott & White clinics dot the Central Texas landscape and employ about 5,600 people. Some 200 medical students and residents from the Texas A&M University Health Science Center in College Station train at Scott & White.

The group practice now has 540 physicians, who, Dr Morehead says, make Scott & White unique. "Integration at Scott & White means that we all share practices; we all watch one another and help one another. That's good for patient care."

That camaraderie and teamwork environment is what attracted Gerald Lyttle, MD, to Scott & White. Dr Lyttle retired from a neurosurgery practice, got bored with retirement, and went back to school to study occupational medicine. He joined Scott & White in 1997 and now heads occupational medicine for its southern region.

In their own words: Scott & White physicians draw up their own marching orders

Physician leaders at Scott & White believe that patients in a preeminent integrated system are more satisfied, that patient outcomes are superior, and that staff and professional morale is higher than in other systems. They have summarized characteristics they believe make for a preeminent delivery system.

GOVERNANCE

- **The system is governed by a community board, including physicians.**
- **Physicians hold major organizational, strategic, and management positions.**
- **Neither decision-makers nor clinicians hold equity interests.**

MISSION

- **The battle cry is, "Do what's right for our patients."**
- **The organization is driven by a desire to improve constantly and by a willingness to make the necessary investments and changes.**
- **The system commits to improve the health of the whole community, not just that of its enrollees/patients.**
- **System leaders are committed to the organizational mission rather than to personal gain.**
- **The system is focused on patient welfare rather than financial performance — to long-term relationships rather than short-term gains. Profits/margins are reinvested into the system rather than distributed to shareholders.**
- **Component parts of the system share common financial goals.**
- **The organization manages consistent growth prudently.**
- **The system is provider-based and provider-friendly.**
- **Clinicians, and not the health plan, make patient care decisions. Practice decisions promote the patients' best interests in light of all social, economic, and ethical factors.**
- **The health plan does not determine which services its enrollees receive but rather facilitates good patient care by supplying information to help providers understand their practices, supervising efficient use of resources, promoting improvement of quality, developing market-sensitive products, and providing physician supervision over all medical care decisions.**
- **The system is permeated with a desire to learn (research) and teach (education).**
- **The system coordinates patient care.**

"It's just an awesome place — very unique. I was very impressed with what it had to offer and how the physicians worked together," Dr Lyttle said.

After having worked virtually autonomously for most of his medical career, Dr Lyttle says he had some trepidation when he joined. "But it was so nice to be able to get on the phone and bend another physician's ear if I had a problem with a patient, or have another physician literally come downstairs and look at a patient. It's a system that's receptive and very responsive to the individual needs of doctors and patients."

That everyone uses the same medical record adds to the organization's efficiency, Dr Morehead says. "With everyone using the same chart, it's easier to track what other clinicians are thinking and to recognize possible slip-ups such as an overlooked abnormal laboratory report."

Dr Morehead believes it's important for the whole medical institution to take responsibility for the quality of patient health care. "It's often difficult for patients to judge the quality of their medical care. But when patients sign up with our health plan, whether they go to our DME store and purchase a piece of equipment, see a specialist and have surgery in our hospital, or use our home health services, they can rest assured that if it has our name on it, they're going to get the best service we can provide."

The most challenging aspect of integrated care is coordinating it, Dr Morehead says. "Say you have a patient with a history of back surgery who develops recurring back pain. Now whom should he see? A spinal surgeon, a physiatrist, a physical therapist? We believe that practitioners in our system should guide that patient to the most appropriate provider. That is very, very difficult to achieve, but we believe it's important for the system to assume that responsibility."

Characteristics of preeminence

On a single sheet of paper, Scott & White physician leaders have summarized what they believe facilitates a superior integrated system (see "In Their Own Words," opposite page).

"We're physician led," said W.E. Lowry, MD, president of Scott & White Clinic. "That might not necessarily make us any better, but it places leaders who are trained and committed to doing what's best for the patient in major decision-making roles."

The presidents of each component — hospital, clinic, and HMO — are physicians. According to Dr Lowry, this governance structure promotes a practice environment that is conducive to professional satisfaction and attracts physicians seeking career opportunities in a patient-focused environment. "It also guarantees careful scrutiny of the impact financial decisions have on patient care," Dr Lowry said. "And it facilitates the profound importance of quality improvements on patient care outcomes."

Dr Morehead says Scott & White's HMO views itself as a "provider of information and monitor of our enrollees' care." Data collected on markers such as immunization and mammogram rates are fed back to physicians. "We look to our physicians to make the appropriate decisions about what care the patients need," he said, "but at the same time, we collect information about how they provide care and give them feedback."

The HMO educates physicians about forces that are changing the demands on the delivery of medicine, Dr Morehead says, and focuses mainly on the appropriateness of care provided to the population, rather than the individual. "Here, physicians practice medicine; the health plan supports the physician's ability to practice consistent and cost-effective medicine."

Cardiologist Jim Rohack, MD, associate medical director for medical operations, is one of the physicians who reviews coverage decisions and tests or procedures that may seem questionable. He says the HMO's whole philosophy is consistent with high-quality care. "Our physicians do not have to wait hours on hold to get approval for a procedure. We make the decisions in-house. They aren't made by someone on the East Coast who may or may not have a medical degree, and 99.9% of the time it's the physician sitting in the office with the patient who decides what is appropriate care."

"We're physician led. That might not necessarily make us any better, but it places leaders who are trained and committed to doing what's best for the patient in major decision-making roles."

And because physicians are salaried, no financial incentive exists to increase or decrease care. "That's just a great way to practice medicine," Dr Lyttle said. "No one is breathing down your neck pushing cost-cutting measures."

Dr Lowry adds that the difference between high and low salaries at Scott & White is much less than in other practice environments. "Our high salaries are lower and our low salaries are higher than most others in Texas."

No individual owns Scott & White. Physicians, administrators, trustees, and investors neither own Scott & White nor receive dividends or have shares to sell, Dr Lowry says. "Therefore, no one has the perverse incentive to sell out to a practice management company or a for-profit HMO for a personal profit. Instead, Scott & White physicians have a particular emotional commitment to remain independent and to continue to call our own shots relative to medical practice."

In Scott & White's system, if one component loses money, another component may balance it. "It's complicated," said John Roberts, MD, president of Scott & White Memorial Hospital Foundation. "That is one reason we're probably not any more popular as a model for others to emulate."

All profits in this physician-led, nonprofit organization are spent on developing new services or improving old ones. Scott & White also spends $20 million per year on charity care.

As a rural but state-of-the-art center, Dr Roberts says, Scott & White offers "big city" medicine in a small town. "Most of our patients come from rural areas, and they typically don't want to get their care in a metropolitan area. They don't like driving in a big city, and here, they can get all of their needs met under one roof."

Scott & White's center in Temple also serves as the clinical campus for Texas A&M University's College of Medicine. "Patients benefit from receiving care in an environment stimulated by discovery and sharing knowledge," Dr Roberts said. "Having medical residents around asking tough questions keeps us on our toes." Residency programs are not cheap either, but Dr Roberts says they're worth the investment.

Physicians also are expected to go beyond just maintaining enough continuing medical education hours to stay licensed and often are called on to give lectures, Dr Morehead says, citing this as one example of the system's commitment to research and education. "Even though their major obligation is to take care of patients, we expect physicians to continue academic pursuits. Practicing 'big city' medicine in a small town requires additional vigilance."

History of excellence

The system that now serves more than 300,000 Central Texans began as a private practice in 1897 with two Santa Fe Railroad physicians, Arthur Scott, MD, and Raleigh White, Jr, MD. The physicians built their practice on three precepts:

- Be honest with patients. Tell them the truth. Treat them as you would members of your own family.
- Be as progressive scientifically as possible within the bounds of safety for each patient.
- Charge patients as modest a fee as possible within the limits of good business practice.

In the early days, the growing practice's hospital was in an abandoned convent and was known as the Temple Sanitarium. In 1922, the name was changed to Scott & White Hospital, and it became Texas' first cancer treatment center approved by the American College of Surgeons.

The Scott & White Memorial Hospital and the Scott, Sherwood and Brindley Foundation are integral parts of the system.

"'Do what's right for our patients' is part of the Scott & White creed," Dr Morehead said. "It's not an empty or glib statement — it's our whole culture." ★

TMA Advantage: Elements of a quality health care plan

Their proponents predict managed care health plans will prove to be the saviors of the American health care system by focusing on prevention, eliminating unneeded services, and assuring the availability of high-quality, low-cost care.

Managed care detractors, on the other hand, insist that the health plans' overemphasis on cost-cutting is undermining patient care. Two thirds of the physicians polled in a recent survey of Texas Medical Association members reported recent instances in which managed care policies adversely impacted the quality of patient care.

The reality, says TMA's Executive Vice President Louis J. Goodman, PhD, is somewhere in between. "We know that some plans are doing an excellent job of controlling costs while protecting patients' rights and honoring the importance of the patient-physician relationship," Dr Goodman said. "Unfortunately, we see examples every day of plans that fall far short of that ideal."

To help physicians and their patients better judge the health plans with which they may sign contracts or in which they may enroll, TMA's Council on Socioeconomics and Council on Communication produced the "Essential Elements of a Quality Health Plan." (See pullout section between pp 48 and 49.) This combination of a four-color office poster for patients and a detailed matrix for physicians provides what Dr Goodman calls "an objective yardstick for measuring the plans."

As its backbone, the project uses the Essential Characteristics of a Quality Health Plan, devised in 1997 by the American Medical Association Center on Society Sponsored Managed Care Organizations. It also incorporated elements from the American Association of Health Plans' Code of Conduct and the "State of Managed Care Quality," produced in 1998 by the National Committee for Quality Assurance. To ensure their accuracy and completeness, the matrix and poster were submitted for review and comment to TMA's Medical Directors' Forum, the Texas Association of Health Plans, the medical directors of several Texas health maintenance organizations, the Texas commissioner of insurance, and the Texas office of a national consumer protection organization.

TMA members can use the postcard inserted in this issue of Texas Medicine to order up to four additional copies of the poster for free. Sets of 10 are available for $20, tax and postage included. Members also may call the Texas Department of Insurance publications order line at (800) 599-7467 to order up to 25 free copies of the brochure/complaint form "Helping You With Your Insurance Complaint" for distribution to their patients.

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Escape from a PPMC

Tarrant County physicians want out of their contract

Artman

When physicians sign an allegedly unfair contract with a management company, who is responsible when things go badly and the doctors want out? One might say the physicians are responsible, because their signatures lead to the assumption that they agreed to the contract terms. Another might say the physician practice management company (PPMC) is responsible if its failure to fulfill its end of the contract — to provide services and pay salaries — is the reason things went so badly.

In the meantime, patients can be neglected, caught up in the crossfire of blame. Whose responsibility are they? ➤➤

By Monica Maldonado, Associate editor

In the end, they are the physicians' responsibility, according to State District Judge Jon Barton of Fort Worth, who has allowed doctors there to continue treating their patients despite the fact that they allegedly are violating their contracts.

The judge's ruling, says an attorney involved in the case, could help move Texas toward joining other states that have outlawed restrictive covenants not to compete.

In *First Physician Corporation of North Texas (FPCNT) v Jonathan Richard, MD,* FPCNT sought an injunction under restrictive covenants in the employment contract between Dr Richard and Health Partners, a physician organization that also has a separate contract with FPCNT for its practice management services. FPCNT also sued to collect damages from Dr Richard for breaching the contract. FPCNT filed as a third-party beneficiary to the contracts, but in a preliminary opinion, Judge Barton denied the application for temporary injunction. He ruled that FPCNT "failed to show that it has a probable right to enforce the contracts in question or that if they do have that right that damages would not provide an adequate remedy."

Dr Richard continues to see patients from his association with Health Partners; however, he no longer sees female patients because he is now with a men's clinic.

At press time, 19 Health Partners physicians were still embroiled with FPCNT, a subsidiary of PhyCor, Inc, of Nashville, over the legitimacy of their employee contracts, specifically the liquidated damages clause, and attorneys for both sides could not predict when it will end.

"These physicians want to be able to practice anywhere they want to practice, without having to pay the liquidated damages," said attorney Douglas Hudman, JD, who represents Dr Richard and seven other physicians. He said he believes these negotiations could last "at least a couple of years," adding, "I think it's fair to say the physicians and PhyCor disagree on all the facts."

At least some of Health Partners' patients who may not have suffered because of FPCNT's alleged mismanagement before might be feeling the effects of the conflict now. Speaking to the Texas Medical Association before the negotiations that began in March, Dr Richard said obtaining the records of patients who stayed with him often took 30 to 60 days after requesting them by fax. "This has directly impacted my care of these patients," he said.

The burden of responsibility for patient care and practice management has always been frustrating to balance, which is why some physicians are receptive to managed care organizations that promise to remove some of that burden.

"These physicians want to be able to practice anywhere they want to practice, without having to pay the liquidated damages. I think it's fair to say the physicians and PhyCor disagree on all the facts."

Health Partners was formed in 1994 by a group of physicians ready to end that frustration, and it built a separate group, Physician Capital Partners, to handle the notoriously mundane yet vital paperwork. It seemed to be a logical and potentially profitable move. Then, in 1996, Physician Capital Partners was acquired by FPCNT. Around that same time, the physicians signed an employee agreement contract with Health Partners, and, according to what Dr Richard told TMA in February, that's when things around the office started to fall apart.

When FPCNT was purchased by PhyCor 2 years later, Dr Richard says, the situation didn't get any better. Phones rang unanswered, patient records were misplaced, and faxes regarding patient prescriptions for a couple dozen doctors bottlenecked into a single fax machine. Whatever frustration the physicians felt before with management became more intense, says Dr Richard. Then, in 1998, two other physicians — Richard Magie, MD, and Kevin Kallal, MD — started thinking they might be better off on their own again and left the group, taking patients with them and allegedly violating contracts.

The contract in question is a common shareholder physician employment agreement, according to TMA's General Counsel Donald P. Wilcox, JD. It states, in a nutshell, that Health Partners will employ and provide services and benefits to the doctors, such as trained staff, equipment, and fiscal management. To protect its business interests, FPCNT is seeking to enforce the restrictive covenants between Health Partners and the physicians.

But the contracts contained little to protect the physicians, argues Mr Hudman, who also represents Drs Magie and Kallal.

In his pleading in the initial suit by FPCNT against Dr Richard, Mr Hudman contended that the contract was unenforceable for many reasons, one being that the promises FPCNT made to pay the doctors of Health Partners were "illusory." Though the physicians were bound by the contract to perform as employees of Health Partners for 5 years, Mr Hudman writes, "the returned promise was illusory in that [neither Health Partners nor] FPCNT, by their own admission, was under [any] obligation to pay any particular salary, or any salary at all, to these doctors."

In fact, the employment contract states that Health Partners "agrees to pay [the] physician an annual base salary," but also says the physician signing the document "acknowledges that Health Partners' compensation policy may be changed from time to time as it relates to physician employees of Health Partners."

Mr Hudman said that despite having produced millions of dollars in fees paid to FPCNT, the physicians "have

Legal articles in *Texas Medicine* are intended to help physicians understand the law by providing legal information on selected topics. These articles are published with the understanding that TMA is not engaged in providing legal advice. When dealing with specific legal matters, readers should seek assistance from their attorneys.

seen their expenses double, their staffs left unmanaged and untrained, their medical records in shambles, their patients' trust destroyed, their incomes dwindled, and their reputations and practices damaged forever."

ployees if they decided to join a competing health care provider. And they shouldn't even think about practicing solo or with an independent group practice if it is not farther than 10 miles from their previous locations.

miles of their previous practices nor would it let physicians refer patients to hospitals within that area. In addition to his opinion that the geographic area is too broad, the judge also denied the injunction against the physicians because he believed that "the actual and potential control exercised by FPCNT over the physicians is so pervasive that it amounts to the impermissible practice of medicine," referring to FPCNT's mismanagement of Health Partners. Because FPCNT is not licensed to practice medicine, this would be categorized as a corporate practice of medicine no-no.

FPCNT attorney Peter Harry, JD, argues that FPCNT is not trying to practice medicine, and that, after all, the contract is between the physicians and Health Partners, which is owned and operated

"Physicians are optimists. They don't see the downside. They're presented with a contract that someone says is a standard contract, and they tend to sign."

Soon after Dr Richard left, Drs Kallal and Magie also left Health Partners; Dr Magie remained in his same office, while Dr Kallal moved a short distance away. Health Partners took action. Though neither Drs Kallal or Magie could discuss the case because it is still in negotiations, Dr Richard, speaking to TMA in February, says that during the weekend after their final day with Health Partners, their patient records were seized and their patients were instructed to see other physicians at Health Partners.

In turning down FPCNT's request for injunction, the judge ruled that Dr Kallal's and Dr Magie's records should be returned and the care to their patients uninterrupted.

Questioning the covenant

Since the initial ruling in this case, 16 more physicians have become involved in the negotiations to determine the enforceability of the employment contract. Specifically, the contract states that if the physicians decide to leave within 3 years of the agreement's effective date, they will be liable for a cash payment of liquidated damages to Health Partners — the sum of their reportable earnings in the past 12 months less the sum of shares in FPCNT. They would hand over any and all documents pertaining to their patients. They could not solicit Health Partners patients for 18 months after termination of employment, nor could they provide health care services within a 25-mile radius of their practice locations as Health Partners em-

Judge Barton pronounced the contract requirements "impermissibly broad" because they would not allow the physicians to see even new patients as long as their practices were within 25

TMA Advantage: Keep an eye on your PPMC

Unfortunately, it's not unusual to hear about physician practice management companies (PPMCs) that don't deliver the goods. (See "Surviving a *Titanic* Ride," December 1998 *Texas Medicine*, pp 37–42.) In such a young industry, accurate statistics that measure physicians' satisfaction with PPMCs and the costs of liability in cases against PPMCs are difficult to come by.

But calculable revenue decreases certainly hint at trouble. So far, 13 PPMCs have reported fourth-quarter (fiscal year 1998) losses of $1.262 billion on revenues of $1.741 million. PhyCor, Inc, of Nashville, reported losing $68 million for the fourth quarter of fiscal year 1998. PhyCor currently operates 54 groups with 3,520 physicians, versus 55 groups with 3,863 physicians at the end of 1997, and the company likely will sell a couple more groups this year, according to industry experts.

Texas Medical Association Physician Services (formerly known as TPSO) offers several resource booklets that can help you through every stage of your relationship with a PPMC. They include:

- ***PPMC Warning Signs Checklist*, which can help you determine the financial and operational abilities of a PPMC.**
- ***Before You Sign on the Dotted Line*, which identifies the primary issues you should consider before you enter into an employment contract.**
- ***Managed Care Model Contract*, which illustrates a balanced agreement between a managed care entity and a physician.**
- ***Extricating Yourself from a PPMC*, which outlines steps you should take from the moment you think you might want out.**

The booklets are available by calling (800) 523-8776. *Before You Sign on the Dotted Line* and *Managed Care Model Contract* also are available in the "Members Only" section of TMA's Web site at www.texmed.org.

by physicians. In Mr Harry's motion to ask the court to reconsider its ruling regarding the injunction, he wrote that the employment contract could not constitute the illegal practice of medicine "because Health Partners is wholly comprised of practicing physicians."

Mr Wilcox said, "The restrictive covenant was indeed between the physicians and Health Partners, but PhyCor/FPCNT sought to enforce it. And their argument was unsuccessful."

Mr Harry also said the physicians produced no evidence that FPCNT was involved in the "diagnosis or treatment of patients or interference with the independent judgment of physicians." He continued, "There was only evidence that some patients might be 'inconvenienced' if the doctors were forced to change offices."

The dotted line

So why did these physicians sign what they later would claim was completely unfair? In his pleading, Mr Hudman argued that the physicians were fraudulently induced to sign the contracts. Among the company's many false or misleading representations, he says, were the promises of "extensive management expertise" and that FPCNT would provide "quality financial management." He wrote, "The fact is that all three of these doctors [Richard, Kallal, and Magie] were induced to sign the employment contracts by a series of promises and representations that were not true."

He also said the final determination on fraud was beyond the scope of this initial judgment, a point brought up again by FPCNT in its challenge to the ruling, calling the presentation of such defenses "premature."

Mr Wilcox offers what might have ultimately led the physicians to sign on. "Physicians are optimists. They don't see the downside. They're presented with a contract that someone says is a standard contract, and they tend to sign."

In TMA's guide *How to Negotiate a Physician's Employment Contract,* Mr Wilcox notes that restrictive covenants are illegal in six states and that in states where they are still legal, they are often the source of bitter litigation.

This spring, the TMA Board of Councilors adopted an opinion discouraging any agreement that "restricts the right of a physician to practice medicine." The opinion of the board also says, "A physician must not be subject to an action for violating a covenant not to compete for continuing to treat patients whom the physician believes will suffer harm if that physician's care must be discontinued in order to comply with the covenant not to compete."

The TMA Council on Legislation says it will "explore legislative action dealing with patient notification and medical record transfers in cases of terminated contractual relationships."

The current opinions of the American Medical Association Code of Medical Ethics offer a guideline for its members, stating: "Covenants not to compete restrict competition, disrupt continuity of care, and potentially deprive the public of medical services. The Council on Ethical and Judicial Affairs discourages any agreement which restricts the right of a physician to practice medicine for a specified period of time or in a specified area upon termination of an employment, partnership or corporate agreement. Restrictive covenants are unethical if they are excessive in geographic scope or duration in the circumstances presented, or if they fail to make responsible accommodation of patients' choice of physician."

> "One of the most important things a lawyer ever told me was that we physicians have rights until we contract them away."

Because there are so many cases that challenge the covenants, a change in TMA policy or even state law could occur, but Mr Hudman has his doubts. "I don't know if this ruling will, by itself, eliminate them, but I think it would certainly move in that direction."

Darren Duvall, MD, a radiologist in Paris, is the former chair of the TMA Resident Physician Section, and has worked with TMA to enact a policy on restrictive covenants for residents. "One of the most important things a lawyer ever told me was that we physicians have rights until we contract them away. And that's what it sounds like these doctors did," he said.

"When it comes right down to it," Dr Duvall continued, "PhyCor is not going to be sued if a lab result doesn't make it to the physicians. Ultimately, we're completely responsible. So we have to be able to defend ourselves."

Mr Wilcox agrees and ponders future contracts between PPMCs and physician groups. "The curious situation here is that in the normal course of things, the physicians at Health Partners would have enforced the covenants. They were in a much better position than third-party FPCNT, but then chose not to do so," he said. "In the next generation of PPMC contracts, you can bet the management company will have a clause that requires the physician group they sign with to enforce the covenants." ★

TMA Advantage:
TMA contract review services

Texas Medical Association members may obtain independent contract reviews for $150 per document. Contact Andre Hampton, JD, attorney-mediator, at 515 Congress Ave, Ste 2000, Austin, TX 78701; (512) 469-9006.

Focusing on the border

Lawmakers, state officials target health needs along the Rio Grande

Ask someone who lives along our state's border with Mexico and he might tell you he lives in the "forgotten Texas." That feeling always has been particularly acute in El Paso, which is separated by one time zone and hundreds of miles from the other major Texas urban areas.

But the 76th Texas Legislature may finally be giving the border its due, at least in the legislative arena. And, with backing from top-ranking state officials, border area lawmakers hope real progress can be made this year in solving health problems that have plagued the border for decades. ➤➤

By Ken Ortolon, Associate editor

"A lot of attention is being directed at the border," said Karen Batory, director of Texas Medical Association's Division of Public Health and Quality.

Indeed, that seems to be true. Governor George W. Bush has made border issues one of his priorities this year. He has directed his secretary of state, Elton Bomer, to be his liaison on border and Mexico issues. Mr Bomer, who was appointed to that post in January, already has made several trips to the region to see firsthand what the conditions are there.

In addition to the governor's interest, Lt Gov Rick Perry has appointed a special Senate Border Affairs Committee, chaired by Sen Eddie Lucio (D-Brownsville) and including most of the senators whose districts border Mexico. That committee has held a series of public hearings to hear from officials such as Secretary of State Bomer, Health Commissioner William R. Archer, MD, and Laurance Nickey, MD, of El Paso, a newly appointed member of the US-Mexico Border Health Commission.

Adding their voices to the debate have been State Comptroller Carole Rylander and US Sen Kay Bailey Hutchison, who has been a staunch advocate of the US-Mexico Border Health Commission.

Building an infrastructure

With so much vocal support for border issues, South Texas and El Paso lawmakers have been quick to take advantage. Numerous bills have been filed to address problems in the so-called *colonias* — the hundreds, if not thousands, of substandard housing developments that dot both sides of the Texas-Mexico border from Brownsville to El Paso. Other measures would mandate childhood immunizations against hepatitis A in border counties, create a Border Health Institute, and direct state medical training resources to places such as Corpus Christi and Laredo.

But the main focus seems to be on infrastructure, which is the root cause of many of the health problems faced by the *colonia* residents and their neighbors.

Jane Dees, spokesperson for Secretary of State Bomer, says infrastructure needs are his primary focus this year, particularly the need for better water and wastewater services in the *colonias*. "Certainly water and wastewater can contribute greatly to good public health along the border," Ms Dees said.

In testimony before Senator Lucio's Border Affairs Committee in February, Secretary of State Bomer recommended creating an ombudsman program in the six most populous border counties to address *colonia* problems. He also proposed legislation that:

- Grants the Texas Water Development Board authority to be part of the engineering and contracting process for *colonia* water and wastewater projects.
- Gives border counties broader authority to grant utility easements in cases where absentee landowners cannot be located, and the right to establish planning boards to stop the proliferation of new *colonias*.
- Asks Texas Atty Gen John Cornyn to increase the number of field investigators in the *colonias* to prosecute subdivision offenders.

Testifying before the Border Affairs Committee in March, Dr Nickey, former director of the City-County Health District in El Paso, showed the committee just how critical water and wastewater needs in the *colonias* are. "The *colonias* are a breeding ground not only for social discontent but disease, as well," he said.

Taking action

Secretary of State Bomer's recommendations already are being acted upon. House Bill 52 by Rep Henry Cuellar (D-Laredo) would allow counties within 50 miles of the border to set up planning commissions to regulate *colonias* and other developments. Senator Hutchison endorsed that bill at a Capitol news conference in February in what was a rare appearance by a federal lawmaker getting involved in state legislative issues. The House quickly passed the measure and sent it to the Senate.

Senator Lucio also has drafted an Omnibus Colonias Bill that includes the provisions of Representative Cuellar's bill and provides border and other economically depressed counties with other tools to control development.

And, the Border Affairs Committee has drafted an infrastructure/development proposal that calls for $250 million in state bonds that target workforce, education, transportation, economic development, housing, and long-term water and wastewater needs in the region.

"By focusing on these problems, we'll be able to attack many of the border health problems that arise from sewer problems, poor housing, and the obvious array of other problems that lead to poor health conditions, especially in the *colonias*," Senator Lucio said. "We want to do everything we can to ensure that the environment that is made available to families is one that is wholesome and free of infectious diseases of any kind."

This is not the first time the state has attempted to address water and wastewater needs in the *colonias*. Since 1989, the state and federal governments have provided nearly $600 million for water and wastewater facilities in the *colonias*. While those funds have helped thousands of *colonia* residents get clean water and adequate sewage, thousands more have been unable to take advan-

"We want to do everything we can to ensure that the environment that is made available to families is one that is wholesome and free of infectious diseases of any kind."

All articles in *Texas Medicine* that mention Texas Medical Association's stance on state legislation are defined as "legislative advertising," according to Texas Govt Code Ann §305.027. That law requires disclosure of the name and address of the person who contracts with the printer to publish the legislative advertising in *Texas Medicine:* Louis J. Goodman, PhD, Executive Vice President, TMA, 401 W 15th St, Austin, TX 78701.

tage of them because they could not afford to have their homes hooked up to the new water and sewer lines.

That will soon change. The Texas Water Development Board recently approved a policy change that, for the first time, will allow government funds to be used to pay for private hookups. Up to $12 million in federal funds will be made available for that purpose, which water board officials say will allow 10,000 households with between 40,000 and 50,000 people to receive free hookups.

> "You don't keep chicken pox on one side and measles on the other. We breathe the same air, we drink the same water, and we share the same diseases."

Inoculating the future

While infrastructure needs in the border region are getting most of the attention, direct health care issues have not been forgotten. Senator Lucio says he will support Senate Bill 615 by Sen Judith Zaffirini (D-Laredo) that requires all public school students in counties within 60 miles of the border to be immunized against the hepatitis A virus. Also, he is backing SB 1378 by Sen Eliot Shapleigh (D-El Paso) that requires the Texas Higher Education Coordinating Board to review medical training needs along the border.

Additionally, the House Higher Education Committee has approved legislation to create a Border Health Institute in El Paso. HB 2025 by Rep Joseph Pickett (D-El Paso) would establish the institute to assist international, national, regional, or local institutions along the Texas-Mexico border in providing health care and health education, and conduct public health research on issues such as infectious diseases, diabetes, environmental health, and children's health. The bill calls for $25 million to be appropriated to The University of Texas (UT) at El Paso and $25 million to the Texas Tech University Health Sciences Center at El Paso to create the institute. The El Paso Community College District, R.E. Thomason General Hospital, the El Paso City-County Health District, the UT-Houston Health Science Center School of Public Health, and the Texas Department of Health (TDH) also would be partners in the institute.

Meanwhile, proposals also are on the table to establish an extension of the Texas A&M System Medical School in Corpus Christi and a Laredo extension of the UT Health Science Center at San Antonio. The Corpus Christi proposal would authorize A&M to increase its medical school class size from 65 to 100 students and to establish a program to provide the last 2 years of medical school training for 35 students in Corpus Christi. While there is concern over whether additional medical school slots are needed in this state, the bill enjoys support among the Corpus Christi medical community.

The UT Health Science Center at San Antonio already sends some of its students to Laredo for part of their training. The bill, proposed by Representative Cuellar, would allow the school to set up its own Laredo campus and move out of rented buildings. The House Higher Education Committee showed support for the bill during hearings in March but deferred action until $16 million needed for the project is appropriated.

Bringing in the feds

While action on border issues was heating up on the state level, Senator Hutchison was preparing to get the federal government into the act. The Texas Republican has asked TMA, TDH, and other interested parties for recommendations on actions Congress might take to improve border health conditions. Quin Dodd, the senator's legislative assistant, says her plans are still in the preliminary stages but legislation will be filed this year.

"We don't want to reinvent the wheel," Mr Dodd said. "We want to find where there are needs and where we can address those needs that are unique or disproportionate to the border, like tuberculosis, cholera, and other communicable diseases."

TMA representatives have met with Health Commissioner Archer and other TDH officials to come up with recommendations for Senator Hutchison. At a meeting on February 25, that group approved five priority issues:

- Directing the US Department of Health and Human Services to create a US-Mexico Border Health Task Force.
- Securing funding for the US-Mexico Border Health Commission on an annual basis.
- Dedicating federal funds to focus on essential public health activities along the border.
- Directing the National Institutes of Health to focus resources for improving the health status of Hispanic populations.
- Directing federal dollars to work with state funds to support broader development of the proposed Border Health Institute.

Crossing the river

While all the action on the Texas side of the border could make a big difference in health and quality of life there, Senator Lucio says Texans cannot forget about their neighbors to the south. He plans to ask for an interim study that would look at needs on both sides of the border. "By addressing the health care needs of our neighbors immediately across the river, we can complement everything that we are trying to do on the Texas side," Senator Lucio said. "It's a must."

As Dr Nickey says, "You don't keep chicken pox on one side and measles on the other. We breathe the same air, we drink the same water, and we share the same diseases." ★

Mutual benefit

TIAA-CREF offers new mutual funds to TMA members

The Texas Medical Association Insurance Trust (TMAIT) has expanded the financial products and services available to TMA members by agreeing with TIAA-CREF (Teachers Insurance Annuity Association-College Retirement Equities Fund), the world's largest pension fund, to offer the TIAA-CREF Mutual Funds. Albert E. Gunn, MD, chair of the TMAIT Board of Trustees, says that until recently, only educators and researchers were able to access TIAA-CREF products. When TMAIT learned that the TIAA-CREF board had decided to allow people outside of education to invest in their new mutual funds, he said, "We thought this was an opportunity that was too good to pass up."

TIAA-CREF has more than $230 billion in assets under management and serves more than 2 million people at more than 8,000 colleges, universities, teaching hospitals, and related education and research organizations. TIAA is the country's third largest life insurance company, based on assets. TIAA-CREF mutual funds are distributed by Teachers Personal Investors Services, Inc, a wholly-owned subsidiary of TIAA.

"TIAA-CREF's mutual funds offer a number of special features that we felt would appeal to TMA members," said Larry Stein, TMAIT administrator.

A TIAA-CREF mutual fund account can be opened with $250. TIAA-CREF lowers the minimum to $25 for those investors who participate in an automatic investment plan. With this plan, investors can authorize TIAA-CREF to automatically withdraw funds from their checking or savings accounts on a semimonthly, monthly, or quarterly basis.

TIAA-CREF mutual funds also have low operating expenses. Ranging from 0.29% to 0.49%, expenses for TIAA-CREF's mutual funds are among the lowest in the mutual funds industry, according to *Morningstar Principia.* (As of December 31, 1998, *Morningstar Principia* tracked 10,373 mutual funds.) A portion of the management fee has been waived. This waiver is contractual

Editor's Note: This article was written by Kirk M. Kozero, second vice president of TIAA-CREF. *Texas Medicine* is printing it as a courtesy to TMAIT.

and guaranteed to remain in effect until July 1, 2000.

Six is enough

TIAA-CREF offers six no-load funds from a range of asset classes. These include the Money Market Fund, Bond Plus Fund, Growth & Income Fund, Growth Equity Fund, and the International Equity Fund. The Managed Allocation Fund, designed for people who prefer to have their asset allocation decisions made by TIAA-CREF's investment managers, also is available.

Although past performance is no guarantee of future results, the funds, which were launched in September 1997, recorded the following performances in the first year: Growth Equity, +35.97%; Growth & Income, +30.51%; International Equity, +19.27%; Managed Allocation, +21.24%; Bond Plus, +8.94%; and Money Market +5.45%. (See accompanying chart for standard performance information.)

The TIAA-CREF Mutual Funds can be mixed and matched to help investors pursue short-, intermediate-, and long-term investment objectives. Investors can also use them as underlying investments for the traditional, Roth, rollover, and education individual retirement accounts (IRAs) that are available from TIAA-CREF.

TIAA-CREF will have an information booth in the exhibit hall at TexMed '99 in Dallas May 6–9. See the TexMed final program for specific location.

TMA members, their families, and employees can obtain free information packages by calling (877) 276-9429, Department FIJ, weekdays between 7 am and 7 pm. Information also may be obtained from the TIAA-CREF Web site at www.tiaa-cref.org/mfunds.

As with any investment, read the prospectus carefully before you invest or send money.

(Note: The quotations in this article are the opinions of one organization and may not represent the experience of others.)

> **"TIAA-CREF's mutual funds offer a number of special features that we felt would appeal to TMA members."**

Performance comparison: TIAA-CREF Mutual Funds vs Benchmark Indices

TIAA-CREF Mutual Funds			Benchmark Indices		
Fund Name	One-Year Total Return* (1/1/98–12/31/98)	Average Annualized Return* Since Inception (9/2/97–12/31/98)	Fund Name	One-Year Total Return* (1/1/98–12/31/98)	Average Annualized Return* Since Inception (9/2/97–12/31/98)
TIAA-CREF International Equity Fund	19.27 %	12.17 %	Morgan Stanley EAFE Index[2]	20.00 %	12.37 %
TIAA-CREF Growth Equity Fund	35.97 %	33.63 %	Russell 3000 Growth Index[3]	35.02 %	30.67 %
TIAA-CREF Growth & Income Fund	30.51 %	29.74 %	S&P 500 Index[4]	28.58 %	28.41%
TIAA-CREF Managed Allocation Fund[5]	21.24 %	20.21 %	Managed Allocation Composite Benchmark[5]	19.59 %	19.24 %
TIAA-CREF Bond Plus Fund	8.94 %	10.23 %	Lehman Brothers Aggregate Bond Index[6]	8.69 %	10.00 %
TIAA-CREF Money Market Fund[7]	5.45 %	5.47 %	IBC Money Fund Report All Taxable Average™[8]	5.04 %	5.11 %
	7-day Effective Yield			7-day Effective Yield	
TIAA-CREF Money Market Fund[7]	As of 12/31/98:	5.09 %	IBC Money Fund Report All Taxable Average™[8]	As of 12/29/98:	4.64 %

* Past performance is no guarantee of future results. The value of your investment will fluctuate. Upon redemption, your shares will be worth more or less than their original price.

[1] It is not possible to invest in an index, and unlike a mutual fund, an index does not incur management expenses.

[2] The Morgan Stanley Capital International Europe, Australia, and Far East (EAFE) Index is an unmanaged index of 1,034 stocks in 20 developed countries, excluding the United States, as of December 1998.

[3] The Russell 3000 is a trademark and a service mark of the Frank Russell Company. The Russell 3000 Growth Index measures the performance of those Russell 3000 Index companies with higher price-to-book ratios and higher forecasted growth values. A subset of the Russell 3000, the Russell 3000 Growth Index contained 1,870 stocks as of December 1998.

[4] Standard & Poor's 500 Stock Index and S&P 500 are registered trademarks. The S&P 500 Index is an unmanaged index of 500 stocks.

[5] The fund's benchmark is a composite. It equals 48% of the performance of the S&P 500 Index, 40% of the Lehman Brothers Aggregate Bond Index, and 12% of the Morgan Stanley EAFE Index.

[6] The Lehman Brothers Aggregate Bond Index is an unmanaged index. The index contained 7,257 issues as of December 1998.

[7] This fund is not insured or guaranteed by the Federal Deposit Insurance Corporation or any other government agency. Although we will attempt to maintain a stable net asset value at $1.00 per share for this fund, it is possible to lose money by investing in the fund.

[8] Source: IBC Financial Data, Inc. The IBC Money Fund Report All Taxable Average™ is an unmanaged index. The 7-day effective yield was available only through 12/29/98.

[9] Reflects the period 9/1/97–12/31/98. Inception date for the TIAA-CREF Mutual Funds was 9/2/97.

The basics of investing in mutual funds

(Editor's Note: This information on mutual funds was prepared with the assistance of the Teachers Insurance and Annuity Association.)

To ensure your future financial security, you should be as knowledgeable about your personal finances as you are about your professional decisions. When it comes to investing, mutual funds are among the most popular choices of today's investors.

A mutual fund combines, or pools, the money that it receives from individuals and institutions. Professional money managers invest the money in stocks, bonds, or other investments. With the money they send to the fund, investors buy shares in the fund. In effect, each mutual fund investor owns a share in the fund's investments. The prices of the fund's shares change daily and are determined by dividing the value of a fund's assets, less its liabilities, by the number of shares outstanding.

Mutual funds offer investors several advantages, including professional money management, diversification, and liquidity. Mutual funds managers research and analyze financial data to determine which investments they believe are most likely to help a fund achieve its objective.

Investing wisely

You should consider several important factors before you invest: your investment goals, time horizon, risk tolerance, and the charges and expenses of the fund(s) that you choose.

Investment managers select investments in each fund to achieve certain stated objectives — maintaining liquidity, preserving capital, providing current income or capital appreciation, or any combination of these terms. Since you need to choose a fund with an objective that most closely matches your own, it's essential that you determine your goal(s) before you invest your money.

Your time horizon is another important factor to keep in mind. This refers to how long you are willing to keep your money invested. Are your goals short-term (1–3 years), intermediate (3–10 years), or long-term (more than 10 years)? Your time horizon is important because it will affect how much risk you are willing — or able — to take with your investments. (Risk is the possibility that your investment will lose or not gain value.)

Over the long term, higher risk investments, like stocks, have generally had greater returns than lower risk investments, like bonds and money market instruments. However, this has not always been the case, especially during short periods of time, and past results are no guarantee of future performance.

Once you've determined your investment goals, time horizon, and risk tolerance, you need to look at the mutual funds' operating expenses and any charges associated with investing because they can directly impact your investment returns.

Depending on the investment company you choose, the funds can have a variety of sales charges — commonly known as "loads" — and other fees that can significantly reduce your returns. Some funds, known as "no loads," do not have sales charges. Investors also need to be aware of the operating expenses associated with a fund because high expenses can decrease your investment's overall returns.

Some advice

Mutual funds are investments, not savings, and how much you earn or lose depends solely on the overall performance of the fund's portfolio. Unlike bank deposits, mutual funds are not backed by a government agency.

With mutual funds, you pay taxes on interest and dividends as well as capital gain taxes. Dividend distributions generally are taxable in the year the investor receives them. Reinvested dividends and capital gains are considered received and, therefore, taxable in the year they are distributed.

If a fund sells securities from its portfolio during the year at a profit, the fund realizes capital gains. Short-term capital gains refer to earnings resulting from the sale of assets held for 12 months or less and are taxed at ordinary income tax rates. Long-term capital gains are earnings from the sale of assets held for more than 12 months and are subject to a 20% tax rate (10% for investors in the 15% tax bracket). If the fund sells shares at a loss, then the fund experiences a capital loss, which may be a long-term or short-term loss.

Many investors find it advantageous to invest in mutual funds rather than individual stocks because fund companies automatically provide investors with year-end reports that illustrate any capital gains and earnings. These reports can greatly simplify an investor's tax reporting process.

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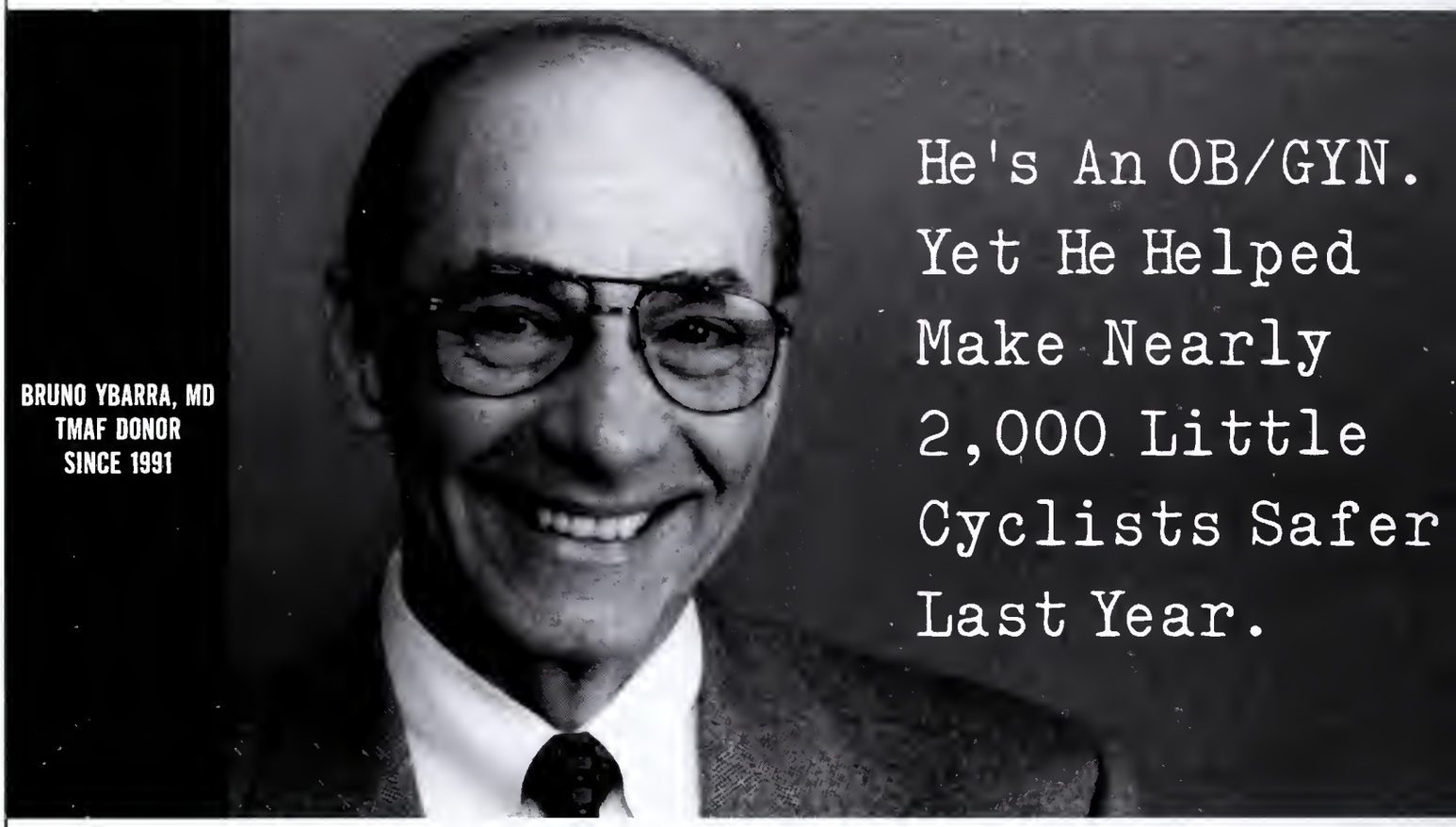

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Recognizing the early stages of dementia

JARY M. LESSER, MD

Dementia is the most common psychiatric problem seen in the elderly, a steadily growing patient group. Cognitive impairment may be difficult to recognize, particularly in early phases, being mistaken for depression, hypochondriasis, or other conditions. Early, correct diagnosis of dementia reduces cases of inappropriate treatment and polypharmacy, and increases likelihood of improving quality of life.

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The elderly form an increasingly important segment of health care practice with dementia being a frequent presenting problem. Some causes of dementia are treatable; specific drugs are now available for modifying the symptoms of Alzheimer's disease, the most common cause of dementia. Therefore, diagnosing dementia as early as possible is desirable.

The fourth edition of the diagnostic and statistical manual of psychiatry (1), in defining criteria for dementia, specifies that the level of impairment in function be sufficient to interfere with daily living. Similarly, many of the rating scales for dementia are so constructed as to be insensitive to mild levels of impairment. Many cases of dementia present with extremely subtle cognitive impairment but significant behavioral change. The preclinical or earliest stages of dementia, where symptoms are vague and subjective, may thus be easily missed.

DEFINITIONS AND VARIETIES OF DEMENTIA

Dementia is a clinical syndrome of chronic cognitive impairment with variable deficits in memory, conceptualization, language, judgment, gnosis, executive function, and insight. In this way, dementia is differentiated from delirium, where the level of consciousness is altered significantly, and from amnestic disorder, where memory and learning are exclusively or disproportionately disturbed.

Dementia has multiple causes. Alzheimer's disease causes 60% to 70% of dementias in older adults; cerebrovascular disease accounts for 10% to 20%; and other neuronal diseases and metabolic, infectious, toxic, nutritional, and neoplastic conditions account for the rest (2). Though the yield is low, a workup is indicated to rule out correctable or reversible etiologies.

The presentation of dementia varies. The kinds of symptoms and the level of disability are determined by many factors, including premorbid intelligence, personality dynamics, degree of cognitive loss, education, and coincident medical and psychiatric illness. Site or sites of pathology also determine the clinical picture, and dementias can be classed as predominantly cortical or subcortical (3). Cortical dementia, typified by Alzheimer's disease, is the classic syndrome of impaired short-term memory, disorientation, apraxia, aphasia, and agnosia alongside relative preservation of personality and social skills. Subcortical dementia, more characteristic of Parkinson's disease, Huntington's chorea, and Pick's disease, shows relatively prominent personality changes and affective symptoms alongside variable cognitive defects (4). Of course, many cases fall in between these 2 types. The subcortical picture is harder to diagnose in early stages, and these patients often are mislabeled as having affective disorders or characterological syndromes.

Thus, subtle personality changes or mood changes may precede demonstrable intellectual losses. It follows then that in many cases of dementia, noncognitive symptoms predominate: personality change and mood change. Two common manifestations are poor social judgment and apparent affective disorder.

POOR SOCIAL JUDGMENT

Persons with subcortical dementia or with frontal lobe dysfunction (as in frontotemporal dementia) may exhibit poor social judgment as a prominent symptom. This can be seen also in intelligent and educated patients who are able to partially mask the cognitive loss. The indications of poor social judgment may be subtle and appreciated only by viewing the process of interaction with the interviewer.

Mr B was a 63-year-old man with an advanced business degree. He was brought in by his wife, who was concerned about problems he was having with his memory. He was still working and driving but felt that his forgetfulness was interfering with his work and causing his driving to be unsure and hesitant. Mr B was a nonsmoker and a nondrinker. He was in good health and took no medication.

Mr B presented himself as a forceful, intelligent but rather blunt and opinionated person. He opened the interview by demanding to know the psychiatrist's credentials. He then stated that he did not want to come, agreeing only to please his wife. He went on to say that he did not believe in psychiatry and would not consent to psychoanalysis, which he felt was a lot of nonsense.

He admitted to his memory problem and wanted it fixed so he could get on with his job. He was fluent and answered questions fully and to the point. He was able to give considerable detail. His thinking was logical and goal-directed without hesitation or verbosity.

On formal mental status testing, he could give the month and day but not the year. When he was given the correct year, he was unable to retain this information for more than 3 minutes. His serial substractions were slow and halting. He could not copy a geometric figure. A Folstein Mini-Mental State Examination (MMSE) was administered, and Mr B scored a 19 (normal score, 30).

Here, we have no clue to the severity of intellectual loss until the formal mental status examination is done. This patient is able to initially mask his cognitive problems, but he cannot conceal his poor social judgment. The overly defensive, truculent tone and impulsivity are unusual for someone with a graduate degree, and are a red flag for the examiner. With formal testing, the degree of decline becomes obvious.

The more common example of poor social judgment is seen in rambling and verbosity. Persons who ramble demonstrate, in addition to a lack of organization, an indifference to the needs of others. Specifically, these patients appear to be oblivious to time constraints and to the annoyance of the listener. The important thing is that rambling and verbosity often precede demonstrable cognitive deficits in the typical presentation of cortical dementia. All too often, such behavioral change is simply ascribed to old age both by family and clinician.

DEMENTIA PRESENTING AS AFFECTIVE DISORDER

Dementia and depression can certainly coexist and be difficult to disentangle. Major depression is uncommon in Alzheimer's disease, although many patients have brief episodes of sadness and poor self-esteem (4). Early or very mild dementia can be mistaken for affective disorder. Patients with frontotemporal dementias in which frontal lobe symptoms are prominent can present either an apathetic, dulled, pseudodepressed picture or a syndrome of disinhibition, resembling mania (5). Subcortical dementias such as seen in Huntington's chorea and the dementia of Parkinsonism may present with significant depression before the appearance of gross intellectual defects, and patients with Huntington's chorea may become actively suicidal (6). Vascular dementias are well known also for prominent depressive symptoms (7). Withdrawal can represent a kind of coping strategy; the demented patient is aware, at some level, of having difficulty processing information and following conversations. Social withdrawal serves to protect the patient from sensory/information overload (and embarrassment) that otherwise might create intense anxiety.

Mrs W, a 78-year-old housewife, had been followed by a psychiatrist for 6 months. She was being treated for major depression. Her symptoms were withdrawal from and loss of interest in housework, her bridge club, and church. She spent much time in bed. Her appetite was increased, particularly for sweets, and she slept several hours during the day but was up most of the night. She was in good health except for mild essential hypertension and hypothyroidism, both controlled. She had tried amitriptyline in gradually increased doses but seemed to become more withdrawn and agitated so that the medication had to be stopped. Subsequent adequate trials of fluoxetine hydrochloride and venlafaxine had produced little change.

The family sought a second opinion. The consultant saw Mrs W as a dulled, quiet, withdrawn elderly woman with a perplexed expression. She was almost mute. With coaxing, she became more verbal, but her speech was halting and she appeared to have word-finding difficulty. She was oriented to person, only vaguely to place, but not to time. Her fund of information was severely limited. Memory testing was difficult because she was poorly cooperative and tended to become agitated and tearful when pressed. She could not copy a geometric figure. Folstein MMSE score was 12.

Neuropsychological testing was requested. Because of Mrs W's poor cooperation and agitation, this had to be performed over several sessions. The testing disclosed moderate-to-severe deficits in memory, expressive language, constructional ability, mathematical skill, reasoning, and judgment.

The consultant concluded that Mrs W was suffering from dementia and suggested a dementia workup, including physical examination, blood work, and computed tomographic scan of the brain.

This case illustrates how ambiguous the presentation of dementia can be. Dementia is suggested by the failure of 3 trials using antidepressants, by problems with memory, orientation, and language, and by a tendency to become agitated when challenged. Note that amitriptyline, a highly anticholinergic medication, seemed to worsen the clinical state, exactly as would be expected for dementia. Once again, the vignette illustrates how easily cognitive impairment can be missed unless it is specifically sought through testing. Finally, the patient becomes tearful when frustrated or agitated, a not uncommon occurrence. This, by itself, should not be mistaken for depression for which a sustained mood of sadness would be more congruent.

OTHER ATYPICAL PRESENTATIONS OF EARLY DEMENTIA

Anxiety

Anxiety is a common symptom in dementia (8) and can be seen as restlessness, fear of being left alone, and clinging behavior. Often, the dementing individual is only vaguely aware of the nature of the problem but realizes that something is wrong, with chronic anxiety resulting. When the cognitive problems are subtle, the correct diagnosis may be missed, and the patient may be treated instead for an anxiety disorder. Treatment with an antianxiety medication may temporarily ameliorate the symptoms but also can make matters worse. If used, a benzodiazepine can further erode cognitive function.

Psychosis

Psychotic symptoms such as hallucinations and delusions usually appear late in the course of a dementia; rarely are they the initial presenting problems (9). First onset of psychosis in late life should always raise suspicion of an organic etiology. Presence of visual hallucinations and a poorly organized, fluctuating delusional system also suggest an organic cause. The psychotic individual may be uncooperative with efforts to test mental status so that correct diagnosis may require a trial with antipsychotic medication and/or hospitalization.

Somatization

Elderly patients tend to somatize for various reasons, and somatic preoccupation can be part of several psychiatric diagnoses, including major depression. Dementia often is accompanied by increased somatic concern and multiple somatic complaints, frequently vague and nonspecific (10). The somatization may be a completely new development or an exaggeration of a preexisting trait.

Hoarding

Hoarding is not an uncommon symptom in dementia and can occur relatively early (10). Individuals may hoard food, scavenged items, or garbage. Often, hoarding is found in company with other signs of frontal lobe dysfunction, such as inattention to housework and personal hygiene, making the distinction with obsessive-compulsive disorder easy.

Ms D was a 79-year-old woman who had been admitted involuntarily to a state mental facility. Ms D had become widowed 7 years earlier and had been living alone, being visited by her son infrequently. Her son's most recent visit had occurred almost a year after his preceding one. On this latest visit, he was shocked to discover the house in a state of disarray with stacks of unopened mail (including several Social Security checks), mounds of garbage, rotting food, and items evidently gathered from neighbors' garbage. His mother was wearing a dirty dress and appeared bland and somewhat indifferent to him. When he attempted to clear away some of the refuse, she became assaultive.

In the hospital, Ms D was generally pleasant and cooperative but tried, repeatedly, to hoard food in her room. On mental status examination, she was a pleasant but rather vague elderly lady with a slightly constricted affect. She was oriented to person and place, knew the name of the president, and could name the month but not the year. She could not do serial substractions, could not copy a geometric diagram, and seemed not to understand why she was in the hospital. She denied problems with her memory and insisted that she was a good housekeeper. Her Folstein score was 16.

DEMENTIA WITH COEXISTING PSYCHIATRIC ILLNESS

"Functional" psychiatric illnesses such as depression and schizophrenia can mimic some aspects of dementia. Schizophrenics may exhibit negative symptoms of blunted affect, lack of motivation, and alogia. Depressives, as mentioned, may be apathetic and withdrawn, and exhibit apparent cognitive deficits. In this context, developing dementia may go unrecognized. As before, the best strategy is careful mental status examination complemented by neuropsychological testing.

Mrs Z was a 67-year-old Turkish-born woman with a long history of bipolar disorder. Her psychiatric illness had been difficult to control with multiple psychiatric hospital-

izations over many years, and she experienced chronic residual symptoms of passivity and hypochondriasis. She had, over time, been tried on many different combinations of psychotropics. Indeed, for her medications to be changed every 2 to 3 weeks was not unusual. One reason for this situation was that Mrs Z attributed many of her somatic complaints to her medications. Her only documented medical problem was controlled hypothyroidism.

Mrs Z's family reported that she was increasingly withdrawn and inattentive to personal hygiene, and decided to seek a second opinion. At the time of the consultation, the patient presented as a well-dressed and groomed older woman, sitting quietly with a pleasant but rather vacant facial expression. Her speech was slow, uninflected, and halting. Mood was bland and affect constricted. Communication was difficult because of the patient's limited English.

She was oriented to person, place, and time, but could not name the US president, and had a very limited fund of information. Serial 3 substraction was very slow, and she lost track of the task. She retained only 1 of 3 objects during a 3-minute period. She could not follow a 3-step command and could not copy a geometric figure. She was aware of her memory problem and insisted it was caused by medication. Folstein score was 15.

A physical examination disclosed a faint resting, pillrolling tremor, bradykinesia, and mild cogwheel rigidity. Her medications were levothyroxine sodium, 0.5 mg daily; lithium carbonate, 300 mg 3 times a day; thioridazine hydrochloride, 25 mg 3 times a day; diazepam, 5 mg 3 times a day; carbamazepine, 200 mg 3 times a day; and fluoxetine hydrochloride, 20 mg twice a day.

The consultant suggested hospitalization to reassess and hopefully to reduce medications, neuropsychological testing, and a neurological consultation. The family agreed, and in the hospital, her diazepam was successfully tapered and her thioridazine was replaced with risperidone 1 mg twice a day. Carbamazepine levels were acceptable, and other laboratory results were normal. Neurological consultation confirmed primary Parkinson's disease, and neuropsychological testing found dementia of moderate severity.

This case has many sources of ambiguity. The patient's limited English can make her seem more impaired than she is; her Parkinsonian symptoms can cause her to behave in a slow, seemingly demented fashion; her chronic regression from psychiatric illness causes impaired functioning; and the diazepam and thioridazine can cause cognitive deficits. Nevertheless, the following points suggest dementia: first, a decline from her regressed baseline has occurred; and second, her short-term memory, calculation, and constructional ability are impaired.

RATING SCALES AND AGING VERSUS DEMENTIA

That the aging process is accompanied by measurable declines in certain intellectual functions has been demonstrated repeatedly. Specifically, ability to learn, speed of mental processing, and mental flexibility appear to decay over time in most people (11). A complex and still unsettled issue is how to distinguish these apparently normal changes from incipient dementia. The dividing line between aging and dementia has been defined arbitrarily in the following way: normal age decline should never progress to the point of interfering with everyday functioning. Obviously, this is somewhat unsatisfying and depends on how rigorously we define normal function.

The next obvious topic is that of dementia rating scales, instruments that are helpful to confirm an impression of cognitive impairment. An exhaustive review of these scales is beyond the scope of this paper, but 4 commonly used scales deserve brief consideration.

The Pfeiffer Scale, a 10-item checklist (12), is quick and easy to administer but fails to assess constructional deficits. The Pfeiffer tests orientation, short-term memory, calculation, and current basic knowledge. Mildly demented patients can achieve a normal score of 10 on the Pfeiffer. The Folstein Mini-Mental State Examination (13) is more comprehensive, includes a figure-copying task, and takes from 10 to 20 minutes to administer. The Folstein is more sensitive to mild dementia and identifies most cases; this test is used widely in clinical practice as well as in Alzheimer research. The Global Deterioration Scale (GDS) (14) is designed specifically for Alzheimer's disease. The GDS is an excellent instrument both for staging the dementia and for distinguishing early dementia from normal aging. The GDS is not a structure interview but a guide for organizing data from the history and mental status to place the patient in 1 of 7 stages, with a view toward predicting the rate of decline. Finally, the Mattis Dementia Rating Scale (15) assesses memory, attention, construction, conceptualization, and initiation/perseveration. This scale is composed of 5 subscales and, while more sensitive to subtle pathology, is also more time-consuming. Cases of subcortical or atypical dementia should be identifiable by the Mattis Scale.

Performance on all rating scales, of course, depends upon the cooperation and motivation of the patient. Limited education also can affect performance adversely on rating instruments as it can on mental status examination. Neuropsychological testing can usually resolve the issue.

CONCLUSIONS AND SUGGESTIONS

Unusual or subtle presentations of dementia and measures to sharpen diagnosis have been described. Early diagnosis is important for several reasons. First, although only a small number of causative conditions are treatable, the longer the delay, the smaller the chance of reversing cognitive loss. Second, unnecessary expense and suffering can result from inappropriate treatment, anticholinergic effects worsening confusion, and the effects of polypharmacy. Third, Alzheimer's disease is becoming an increasingly manageable, modifiable disorder; specific medications can now ameliorate some of the memory loss. Finally, we have evidence, admittedly incomplete, that agents such as Vitamin E and anti-inflammatory drugs may delay the onset and slow the progression of Alzheimer's disease. For all these reasons, sensitivity to the recognition of dementia in the elderly can only be an advantage.

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Pulmonary embolism mimicking acute myocardial infarction

CHRISTOPHER B. WONG, MD
IAN T. TANG, MD
ALEX TIU, MD

Pulmonary embolism is a major cause of death in the United States. A high index of suspicion is required to achieve an accurate diagnosis. We report a case of a patient with syncope, ischemic electrocardiographic changes, and an elevated troponin I level, presenting just like acute myocardial infarction. The case highlights the value of an early use of 2-dimensional echocardiography in obtaining an accurate diagnosis, thus avoiding unnecessary and inappropriate treatment.

Pulmonary embolism is a major cause of morbidity and death in the United States (1). In spite of improved diagnostic tools in modern medicine, 75% of all pulmonary emboli go undiagnosed. A high index of suspicion is required to achieve an accurate diagnosis. In this article, we present a patient with pulmonary embolism who presented with syncope, ischemic electrocardiographic changes, and an elevated troponin I level mimicking acute myocardial infarction.

CASE REPORT

The patient, a 72-year-old Hispanic female, was fully ambulatory and in her usual state of health until 12 hours before admission, when she had a near-syncopal episode. She described feeling very dizzy when she stood up. She experienced diaphoresis and nausea but no shortness of breath or chest pain. She was seen subsequently in the emergency room, where abnormal electrocardiographic changes were noted. She never had any problems with deep venous thrombosis and denied any history of coronary artery disease. Her past medical history was remarkable only for hypertension and hypercholesterolemia. Her medications were Zestoretic and vitamin tablets.

Physical examination revealed blood pressure 110/70 mmHg, heart rate 68 beats/minute, normal respiratory rate and temperature, normal first and second heart sounds without any murmurs or gallops, clear breath sounds, and normal lower extremities. The initial radiograph of the chest was normal. A 12-lead electrocardiogram (Figure) revealed normal sinus rhythm (rate 64/min), a small S wave in lead I, Q wave in lead III, and T wave inversion V1 through V4. Troponin I level was elevated at 3 ng/ml (normal, less than 0.6 ng/ml). Creatine kinase was normal but the MB isoenzyme of creatine kinase was elevated at 8.1 ng/ml (normal, less than 5.0 ng/ml). At that time, a non-Q wave myocardial infarction was suspected. The patient was given intravenous heparin, aspirin, ticlodipine, and a nitroglycerin patch.

An emergent 2-dimensional echocardiogram was performed to assess the extent of ischemic area. To our surprise, the left ventricular systolic function was normal, without any wall motion abnormalities. The left ventricular ejection fraction was preserved at 0.60. However, the interventricular septum appeared to be flattened with a grossly dilated right ventricle (2.9 cm) and severely depressed right ventricular systolic function. No intracardiac thrombus was seen. The Doppler-derived pulmonary arterial systolic pressure was 50–55 mmHg, suggestive of moderate pulmonary hypertension. An arterial blood gas while the patient was receiving 2 L/minute oxygen revealed pH of 7.41, pCO_2 of 29 mmHg, and pO_2 of 57 mmHg, with an arterial-alveolar gradient of 107 mmHg. These findings were compatible with acute pulmonary embolism.

A subsequent ventilation-perfusion scan did reveal a large perfusion defect in the lower lobe of the right lung and normal ventilation. Venous Doppler of lower extremities revealed a deep venous thrombus in the left common femoral vein. Because of the hemodynamically significant pulmonary emboli (which caused syncope and severe right ventricular dysfunction), we decided that an inferior vena caval filter was necessary to prevent recurrent pulmonary embolism, which could be fatal. On day 3 of hospitalization, an inferior vena caval filter was implanted by percutaneous technique in the inferior vena cava below the renal veins. During the implantation of this filter, a coronary angiogram was performed; it revealed no significant coronary artery stenosis other than a 40% narrowing in

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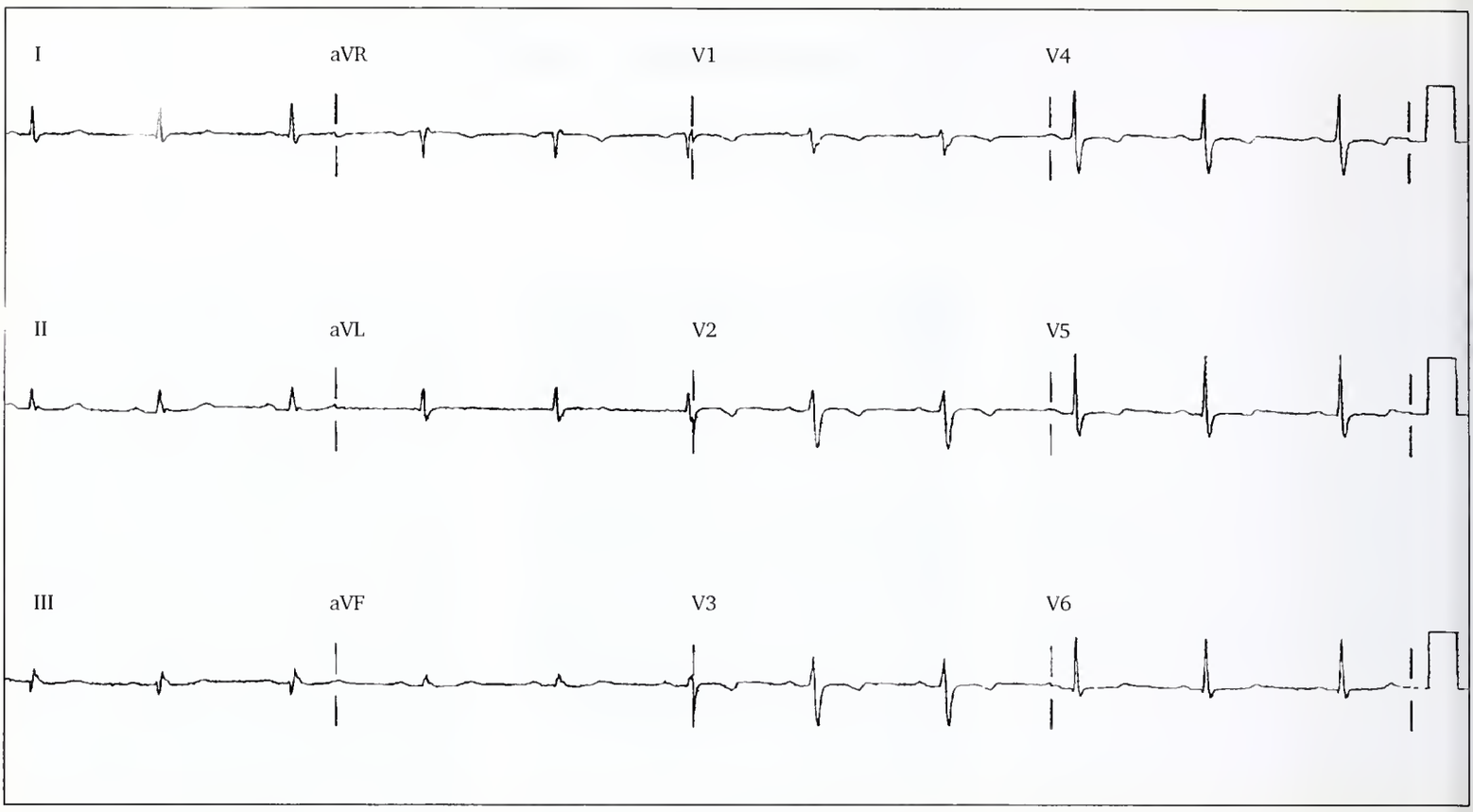

A 12-lead electrocardiogram shows T wave inversion V1 through V4, a small S wave in lead I, and Q wave in lead III.

the mid right coronary artery. The left ventriculogram revealed a normally contracting left ventricle. Subsequent workup for an occult malignant disease was unrevealing. The patient was subsequently discharged to her home on oral warfarin, and she continued to do well in the subsequent clinic visits.

DISCUSSION

Pulmonary embolism and deep venous thrombosis are common forms of cardiovascular illness in the United States. Diagnosed and treated properly, pulmonary emboli rarely have a fatal outcome. However, undiagnosed pulmonary emboli still constitute a major cause of morbidity and mortality. In the patient described above, the presentation exactly mimicked acute myocardial infarction, with ischemic electrocardiographic changes and an elevated troponin I level. On the other hand, she had absolutely no risk factors for acute pulmonary embolism. The only diagnostic test that "saved" us from further inappropriate treatment was echocardiography. Although echocardiography usually cannot demonstrate the pulmonary emboli directly, echocardiographic signs of pulmonary embolism including a dilated right ventricle (25 mm or above), abnormal septal motion, and an abnormal tricuspid regurgitant peak flow velocity (2.5 m/second or above) are valuable to support the diagnosis of pulmonary embolism (2). In fact, these 3 signs were present in our patient. More importantly, the fact that the echocardiogram showed a normal left ventricular systolic function with no wall motion abnormality spoke against the diagnosis of acute myocardial infarction.

The use of the troponin I test has been shown to have an independent diagnostic and prognostic value in patients suspected to have an acute myocardial infarction (3). In the current case, the high troponin I level apparently reflected a small right ventricular myocardial damage secondary to the acute pulmonary hypertension exerted by the emboli. The subsequent coronary angiogram did not reveal any significant coronary artery stenosis.

In conclusion, this case demonstrates that pulmonary embolism can mimic acute myocardial infarction, with ischemic electrocardiographic changes and elevated cardiac enzymes. Obtaining a correct diagnosis of pulmonary embolism can be difficult, especially in patients with no risk factors for pulmonary embolism. Although not diagnostic, an early use of echocardiography in patients with "acute coronary syndrome" will guide the physicians to a correct diagnosis, thereby avoiding unnecessary and inappropriate treatment.

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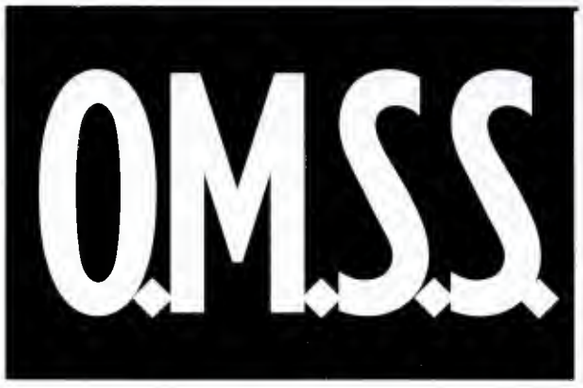

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OMSS membership is open to TMA members with active hospital medical staff privileges. To designate your hospital's TMA-OMSS representative, please complete and return the following information:

Physician's name _____

Preferred mailing address _____

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Office phone _____

Fax number _____

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Hospital name _____

Practice Type: ☐ solo ☐ group ☐ hospital-based

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_____

chief of staff or secretary of medical staff signature date

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Southwestern Center for Minimally Invasive Surgery: Urology, June 4-5. Sponsored by UT Southwestern Medical Center at Dallas. Excellence in Education Foundation Auditorium, Simmons Biomedical Research Building. Course Director: Margaaret Pearle, MD, AMA credit offered. Contact: Leah Cannon, program coordinator (214) 648-3792.

Science of Family Medicine, June 9-13. Sponsored by UT Southwestern Medical Center at Dallas. Excellence in Education Foundation Auditorium, Simmons Biomedical Research Building. Course director: Claire McCluggage, MD, and Joe Ventimiglia, MD. AMA and AAFP credit offered. Contact: Lisa Dunlevy, program coordinator, (214) 648-9532.

Update in Pain Management, June 12. Sponsored by UT Southwestern Medical Center at Dallas. Excellence in Education Foundation Auditorium, Simmons Biomedical Research Building. Course director: Noor Gajraj, MD. AMA and AAFP credit offered. Contact: Stacey Novotny, program coordinator, (214) 648-3784.

The Third Annual Enhancing Your Clinic Practice Using New Technology, June 19 (pre-conference June 18). Sponsored by UT Southwestern Medical Center at Dallas. McDermott Plaza, D1.700. Course director: Ron Peshock, MD. CME credit offered. Contact: Kraig Steubing, program coordinator, (214) 648-9350.

Physicians at the Crossroads, June 25. Sponsored by the Alliance for Medical Management Education. UT Southwestern Medical Center at Dallas, Excellence in Education Foundation Auditorium, Simmons Biomedical Research Building. Course director: Willis Maddrey, MD. AMA credit offered. Contact Kathy Matthews, program coordinator, (214) 648-2200.

Zale Lipshy University Hospital Minimally Invasive Surgery Overview for the Primary Care Physician, June 26. Sponsored by the Southwestern Center for Minimally Invasive Surgery, UT Southwestern Medical Center at Dallas, Excellence in Education Foundation Auditorium, Simmons Biomedical Research Building. Course director: Daniel Jones, MD. CME credit offered. Contact Kathy Matthews, program coordinator, (214) 648-2200.

BackTalk

Question

Are you concerned about the impact the Y2K problem could have on medicine? Why or why not?

"I don't believe that January 1, 2000, will bring Armageddon upon us as many have implied. I am concerned that until that date we don't truly know the penetration into our everyday lives and the ramifications of the failure that older computer systems represent. I think every agency and physician should develop a plan to scour their computer world to make certain that critical systems are Y2K compliant. I am cautiously optimistic that only minor glitches in noncritical systems will be encountered. I have no intention of hoarding water and canned food this fall."

Philip Suarez, MD, 43
obstetrics-gynecology, Victoria

"As an emergency physician, I am worried that the New Year's Eve celebration may be more disruptive and extensive than usual due to the millennium change. Even with just a few computer problems, if we have more patients in the ED over a long weekend with on-call specialists stretched thin, we may be in for a huge emergency department buildup."

Diana Fite, MD, 46
emergency medicine, Waller

"We have organized the Dallas Virus Response Team, composed of physicians and engineers who research viruses and software bugs. We feel that if we understand Y2K, we will not fear it."

Cyrus Peikari, MD, 29
internal medicine, Garland

"Health care in Texas is at risk for year 2000 disruptions of both computer systems and medical devices. Working with vendors and consultants, most of the more important systems will be fixed in time. Medical devices that use data chips and computers (eg, CT scanners, blood analyzers, and ECG carts) make up the majority of our expected year 2000 remediation costs."

Mitchell Morris, MD, 43
gynecological oncology, Houston

"I'm a little concerned about the possible loss of telephone and electrical service the first day or two. And I'm expecting to get paid a little late by the insurance companies that month. I'm planning to have all my batteries charged and have a couple of battery-powered lanterns ready for the exam rooms, if necessary. (We already use them when the electricity goes out.) Our office computer systems are all fewer than 2 years old, so they should be Y2K compliant. I'm much more worried about the possibility of people panicking than actual electrical or computer failures."

Beverly Nuckols, MD, 43
family practice, New Braunfels

"I do not have to worry about the impact of the Y2K bug on medicine because my wife and all the religious right are taking care of it for me. I am not sure why one religious group became so concerned about this problem. If things shut down, I hope my phone won't work, and I will go fishing."

James H. Harris, Jr, MD, 57
internal medicine, Marshall

Back Talk is a nonscientific sampling of Texas physicians' opinions on a topic of interest. Physicians are polled by telephone, fax, or e-mail. We welcome suggestions for future topics. Send them to *Texas Medicine*, Back Talk, 401 W 15th St, Austin, TX 78701; fax them to (512) 370-1632; or e-mail them to m_mcever@texmed.org.

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*Accidents are the leading cause of death for people under age 38. *Accident Facts*, National Safety Council, 1997.

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The potential for the information gained from genetics research to revolutionize medicine is incredible, but are physicians really using it to benefit their patients? Many doctors stop short of actually suggesting genetic screenings to their patients because of concerns over the cost and the lack of guidelines about how to deal with positive results. There are many questions but, for now, few answers.
By Monica Maldonado

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June 1999

Law

Calming fears 26

Expecting the FBI to show up in your office any minute now and slap the cuffs on you? Many physicians are, with all the talk from Washington about cracking down on Medicare fraud and abuse. But the fact is most physicians have done nothing wrong and have nothing to fear. Hospitals and home health care agencies have been the major targets thus far. Still, there are a few things to keep in mind.

By Monica Maldonado

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If you've got teenagers haunting your house, you know how difficult it can be to talk to them about some subjects. And because many parents can't, or won't, talk to their kids about sex, drugs, smoking, or other risky behaviors, it often falls to physicians to find out what's going on in teens' lives and help them make the right choices.

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It shouldn't even be an issue, but it is. Who should make the medical decisions about what's best for a patient? The person who holds a medical degree or an insurance company? A fierce battle is being waged in Congress over that issue, with insurance and business lobbyists predicting the end of civilization as we know it, if physicians continue to make such decisions.

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The Y2K scare may turn out to be, as they say in West Texas, all hat and no cattle, but you'd better be prepared just in case. Texas Medical Association Physician Services offers some advice on how to avoid problems.

By Teri Moran

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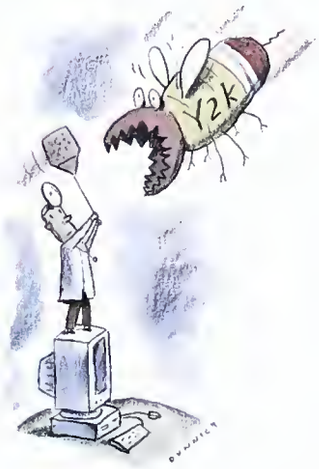

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The Big Picture

Bluebonnets and Indian paintbrush along the Trinity River near Fort Worth, by Daksha Patel, MD, Fort Worth
If you would like to submit a photograph for The Big Picture, please send it to Laura J. Albrecht, Photo Editor, *Texas Medicine*, 401 W 15th St, Austin, TX 78701.

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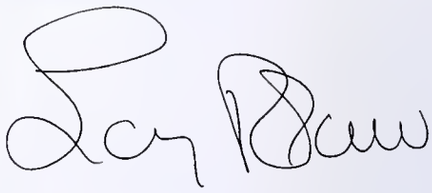
Editor's Note

When I was in high school (Gainesville High School, Class of '65), the biggest trouble we could get into was going to Johnny's B-29 Club across the Red River in Oklahoma where they didn't observe the formalities of checking IDs. Only the "bad girls" got pregnant, only the "hoods" smoked, the only guns we saw were for deer or rabbit hunting, and we were saving our drug experimentation for college.

I'd hate to be a teenager today. Today's teens routinely face the temptations and hazards of sex, tobacco, alcohol, drugs, and random violence, sometimes even in supposedly "safe" schools, as we were so tragically reminded recently.

That's why it's so important for physicians to talk to teens and get them to open up and tell someone what's going on in their lives. They're more likely to confide in you than their parents about sex and drugs.

But how do you get them to talk about such matters? In this month's Public Health section, Senior Editor Teri Moran talks to several experts and gives you tips on communicating with your teenage patients. What you do and what you say to them can have a tremendous impact.



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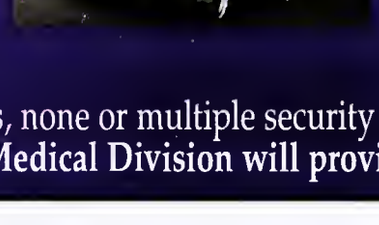

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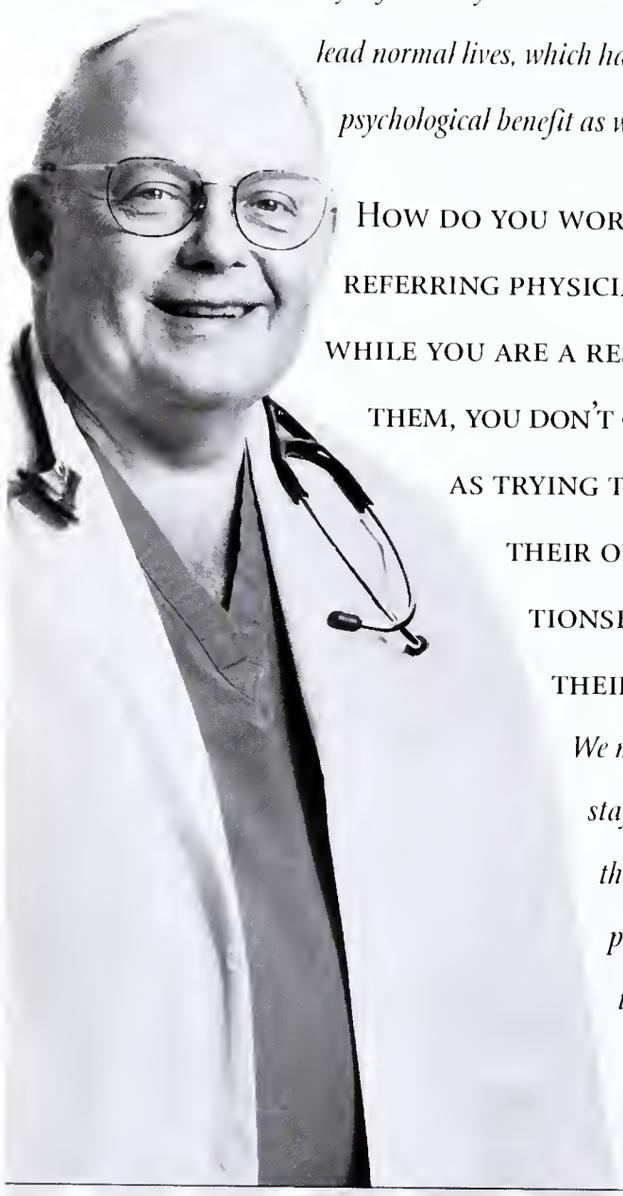

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Letters

Been there, survived that

It is rare to find a topic in a journal that presents information that is so universally germane to all who are in the practice of medicine, but the articles in the March 1999 issue dealing with the effects of stress do just that. (See "Stress, Burnout, and Addiction," pp 42–52.)

In his book, *The Tennis Partner: A Doctor's Story of Friendship and Loss,* Dr Verghese writes passionately and compassionately about his friend David Smith, MD, and how stress led to reactivation of his addiction and ultimately to his demise. Applause also goes to the cover story, part three, "Living with 'Success Stress,'" with the comments by Wayne Sotile, PhD, and Edgar Nace, MD. We do not have to look very far to find someone in our profession who has suffered with the pains of addiction. In fact, all too often, all we have to do is look at the face in the mirror.

I believe that the most important message offered in the articles is that physicians do not have to suffer in silence. The Texas Medical Association and the Texas Osteopathic Medical Association both have Physician Health and Rehabilitation committees whose sole function is to help physicians and their families find help when the need arises.

By working with our colleagues in the committees and our colleagues in practice, we can find compassion and the treatment we need to continue our work in the field we so love.

How do I know? Been there, survived that.

Weldon E. Glidden, DO
303 Ave I, Box 370
Chillicothe, TX 79225

Honesty is best

The wisdom that Dr Rahman expressed in the Forum on Ethics ("Compassion by the Bedside," April 1999 *Texas Medicine*, pp 30–31) is laudable. Being a hospice physician, I can vouch for his statement that "we do a disservice to patients and often put them through unnecessary trauma by not being frank with them." This is true in any health care setting, not just oncology.

He also states that "false hope can undermine patients' confidence in their doctors." Heaven knows the medical profession doesn't need to be a party to the erosion that already exists because of the current health care reimbursement system, where many of us are no longer physicians offering the best advice, but gatekeepers keeping a lid on costs. Are we then good stewards of the health care dollar? No, we are greedy doctors trying to make more money at the expense of the consumers' health!

Like many hospice physicians, I do this part-time. My "day job" is in a primary care clinic. I face this kind of thinking by patients every day when I don't give them the referrals they seek. It is difficult telling a parent that I can treat mild acne as well as a dermatologist can. A 15-minute appointment becomes a 20- or 30-minute discussion of acne pathophysiology. That extra time spent establishes trust. The point is that somehow we don't have the time to provide honest communication. It is a cop-out, yet I hear this all the time when I talk to physicians about how to break bad news and discuss advance directives. Are we putting patients first or are we just hollow echoes of that battle cry?

Perception is reality. The perception by many of my hospice patients is that their doctors lied to them about the seriousness of their diseases. The truth is, about half the time, we (the hospice) are the ones telling them they have terminal illnesses. Fifty percent of the patients referred to my program don't yet know they have incurable diseases!

I am heartened to hear that Dr Rahman has the commitment to spend the time for honest communication with his patients. The conversations he has are of a greater magnitude than my acne conversations, but he could cop-out and give more chemotherapy, as I could yield and give that mom a refer-

Express your point of view in *Texas Medicine*. To submit a letter, mail, fax, or e-mail it to *Texas Medicine*, TMA, 401 W 15th St, Austin, TX 78701; fax (512) 370-1632; e-mail larry_b@texmed.org. Please type letters you submit for publication, and keep the length to 400 words or less. If necessary, you may include a few references, preferably less than five. Letters are published at the discretion of the managing editor and editorial advisors, and are subject to editing and abridgment. Letters represent the opinions of the authors and do not necessarily reflect the policies of the Texas Medical Association.

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Dennis S. Pacl, MD
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Government regulations ridiculous

One more time! For some 20 years now, I have been urging physicians to place, in their waiting rooms, documents provided by Medicare, Medicaid, various health maintenance organizations (HMOs), etc, so patients can read for themselves the rules and regulations placed between physicians and their patients, and see for themselves the "hideously complex, incomprehensible government forms" Dr Nancy Dickey (American Medical Association president) complains of in TMA's *Action* (March 1999).

Each time, I am met with the response that if "highly trained" medical *doctors* have trouble understanding them, how can one expect relatively uneducated patients to understand them, which is just the point! Let patients read how these "highly trained" *doctors* pay out hundreds of dollars to have these matters explained to them. Let patients read how "providers" are forced to sign that they understand that "anyone who misrepresents, falsifies, or conceals essential information required for payment of federal or state funds, may be subject to fine, imprisonment, or civil penalty under applicable federal and state laws." (I usually add, "I also recognize that should I run a stop sign, I may be subject to whatever penalty applies.")

A classic example is the Special Medicare Bulletin No. 1 of May 1, 1998, which requires that the date of birth be reported as MM—DD—CCYY, except item 24a which requires a continuous number MMDDCCYY. Failure to follow this requirement will result in nonpayment. (And if the goofy government lawyers who write these absurdities consider such failure as "concealment of essential information required for payment," then the "provider" may find

himself in prison.) HMOs insist that "providers" not criticize them, so I suggest letting patients read HMO writings for themselves without comment from the "provider."

Dr Dickey and others of the AMA don't yet understand that they are members of a special interest group that spends more money in Washington than any other such group, whereas their patients are the electorate!

The super-intelligent and super-trained "providers" may continue to disagree, so I am sending this also to the American Association of Retired Persons.

G. Curtis Hoskins, MD
7615 St Hwy 36 E
Cross Plains, TX 76443

Join TEXPAC!

It never ceases to amaze me when I attend a TEXPAC meeting, which I did recently in Austin for Capitol Check-Up, to find out what a zealous group of government relations staff, aka lobbyists, we are privileged to have fighting our battles in the legislative halls on a daily basis. The most chagrining issue is that only 20% of physicians who are members of the Texas Medical Association are members of TEXPAC. Look, folks, this is simply a $100 contribution per year, or $300–$500 if you are particularly involved. I personally feel that it is shameful that physicians don't support our legislative team.

Believe me, I've heard all the excuses: "They always support the friendly incumbent." "They supported Ann Richards!" "They had the nerve to give Martin Frost financial support." I would agree that some of these decisions are "mind-boggling events," but we must trust our staff. They are zealously on our side for gaining access to influence our legislators to try to preserve the profession that we love. They take all their decisions and recommendations to the TEXPAC board, based on their fundamental principles of doing what's best to help us preserve our profession. We must trust our fellow physicians on the TEXPAC board, as well as our lobby staff.

I must admit, it is oftentimes very seductive to simply walk away and do nothing. I would submit to you, however, that if good people are not involved in government, you know what will happen. Yes, the legislative cycle is crisis management, and you would not believe the barrage of junk that the legislators have to deal with. Our legislators, in general, are well intentioned and educated. They do believe, fortunately, that physicians are still honest and aboveboard, but others out there are trying to erode the trust we have earned over decades.

I strongly encourage every Texas physician who is not a member of TMA to join, and I encourage every TMA member to become a member of TEXPAC at whatever level he or she desires. It is simply no longer acceptable for some physicians to let others "carry the load." It would be shameful for our profession to simply be run over by inattention and neglect!

Lee S. Anderson, MD
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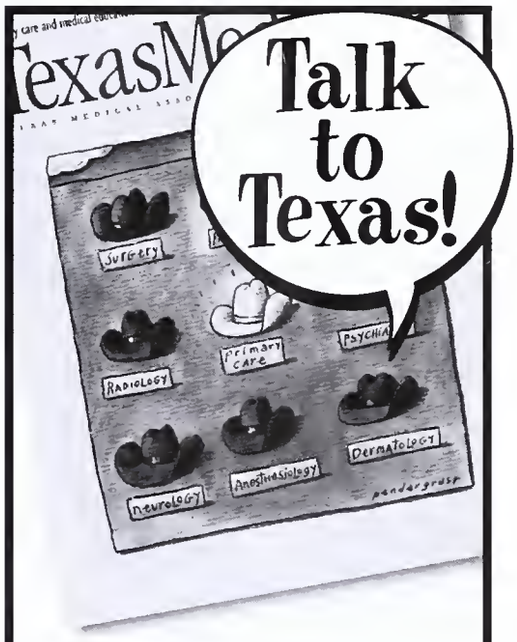

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TexasMedical Association

People

Newsmakers

Otolaryngologist **Bobby Alford, MD;** cardiothoracic surgeon **Denton Cooley, MD;** and head and neck surgeon **Helmuth Goepfert, MD,** all of Houston, received Distinguished Surgeon awards from the Association of Operating Room Nurses for their contributions to the medical community.

Internist **Ron J. Anderson, MD,** was named Public Administrator of the Year by the North Texas Chapter of the American Society for Public Administration for his work as president and chief executive officer of Parkland Health & Hospital System in Dallas.

Belton retired gynecologist **Wayne F. Baden, MD,** was honored on his 80th birthday with the passage of House Resolution 288, which was sponsored by State Rep Dianne W. Delisi (R-Temple) and recognized Dr Baden's lifetime work.

San Antonio pediatrician **Dianna Burns, MD,** was appointed to the board of directors of Primary CareNet of Texas.

San Antonio cardiothoracic surgeon **Alfonso Chiscano, MD,** received the American Heart Association's Heart of Gold Award.

Ron J. Anderson, MD

Wayne F. Baden, MD

J. Fred Mullins, MD

J. James Rohack, MD

Houston rheumatologist **J. Michael Condit, MD,** was elected chair of The Arthritis Foundation, South Texas Chapter.

Maureen A. Finnegan, MD, Dallas, was elected to the Board of Councilors of the American Academy of Orthopaedic Surgeons and the American Association of Orthopaedic Surgeons; and **James D. Heckman, MD,** San Antonio, was elected to the Board of Directors of the academy and the association.

Cardiovascular disease specialist **Robert Fordtran, MD,** and radiation oncologist **Vernon Medlin, MD,** both of Corpus Christi, were honored for their years of service by Christus Spohn Health Systems.

Houston cardiothoracic surgeon **Charles Fraser, Jr, MD,** received a 1999 Outstanding Young Texas Ex Award from The Ex-Students' Association of The University of Texas at Austin.

San Antonio otolaryngologist **William W. Gordon, MD,** was elected to the Texas Medical Association Insurance Trust Board of Trustees.

Family practitioner **Perry E. Gross, MD,** was honored with the establishment of the Perry E. Gross M.D. Distinguished Chair in Family Practice at The University of Texas Southwestern Medical Center at Dallas. The chair was created with a $1 million gift from Dallas philanthropists Linda and Milledge Hart III. **Shelley P. Roaten, Jr, MD,** Dallas, will be the first holder of the chair.

Houston neurologist **James C. Grotta, MD,** received the 1999 William A. Feinberg Award of Excellence in Clinical Stroke by the National Center of the American Heart Association.

Houston neonatal-perinatal medicine specialist **Charleta Guillory, MD,** received the Distinguished National Volunteer Service Award from the March of Dimes.

Please let *Texas Medicine* know about your honors and achievements. Criteria for inclusion in the Newsmakers section are TMA membership; election or appointment to an office of, or honors from, a national or state organization; or, space permitting, recognition at the local level. Items for the Newsmakers section are published at the discretion of the managing editor. Submit items for consideration, with photos if possible, to Johanna Franke, People, *Texas Medicine*, 401 W 15th St, Austin, TX 78701; fax (512) 370-1632; e-mail johanna_f@texmed.org.

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The Texas Medical Association Stroke Prevention Project is a joint project of TMA and the American Heart Association, Texas Affiliate, Inc, and is endorsed by the Texas Department of Health. Seminars are sponsored in part by an unrestricted educational grant from DuPont Pharma through the TMA Foundation.

People

Byron L. Howard, MD, Dallas, and **Alice R. Mao, MD,** Houston, were named recipients of the Tenth Annual Nancy C.A. Roeske, M.D., Certificate of Recognition for Excellence in Medical Student Education by the American Psychiatric Association and its Committee on Medical Student Education.

Cardiothoracic surgeon **Jimmy F. Howell, MD,** was honored at the Houston Chapter of the American Heart Association Young at Heart Ball.

General surgeon **Sally M. Knox, MD,** and emergency medicine specialist **Ellen Taliaferro, MD,** both of Dallas, were included in a list of remarkable Texas women created by *The Dallas Morning News* to celebrate Women's History Month in March. Dr Knox was listed for founding the Bridge Breast Center to diagnose, treat, and assist low-income or uninsured women, while Dr Taliaferro was included for her work to break the cycle of domestic violence.

Shang-Chu Loh, a second-year medical student at Texas A&M University College of Medicine in College Station, won a Stanley J. Sarnoff Fellowship in Cardiovascular Research.

Longview general surgeon **Ben Mack, MD,** was chosen 1999 Doctor of the Year by the *Longview News-Journal.* Longview family practitioner **Larry Huffman, MD,** and Gilmer family practitioner **Steve Murry, MD,** were selected as runners-up.

Houston pediatrician **Margaret C. McNeese, MD,** was named the Ashbel Smith Distinguished Alumnus for The University of Texas Medical Branch at Galveston.

Dallas internist **Jere Mitchell, MD,** received the Distinguished Scientist Award from the American College of Cardiology.

Austin dermatologist **J. Fred Mullins, MD,** received the Excellence in Teaching Award from the School of Medicine Alumni Association Board of Trustees at The University of Texas Medical Branch at Galveston.

Abilene psychiatrist **Pete Palasota, MD,** received the Community Service Award from the Taylor-Jones-Haskell County Medical Society.

Baytown family practitioner-geriatric medicine specialist **Keith Rapp, MD,** was elected vice president of the American Medical Directors Association.

Gastroenterologist **Mark Richards, MD,** was named director of the Division of Medicine at Scott & White Clinic in College Station.

Dallas neurologist **E. Steve Roach, MD,** received the 1999 Outstanding Alumnus Award from the University of Tennessee College of Medicine in Memphis.

Temple cardiovascular disease specialist **J. James Rohack, MD,** was appointed to a 3-year term to the Liaison Committee on Medical Education by the American Medical Association Board of Trustees.

General surgeon **F.A. Smith, Jr, MD,** received a 3-year appointment as Cancer Liaison Physician for the Hospital Cancer Program at St David's Medical Center in Austin. The Cancer Liaison Program, a network of more than 1,800 volunteer physicians, is part of the Commission on Cancer of the American College of Surgeons.

Houston nephrologist **Wadi Suki, MD,** received the Ben Qurra Award from the Arab American Medical Association of Houston.

Physical medicine and rehabilitation specialist **Nicolas Walsh, MD,** was appointed an executive associate dean of The University of Texas Health Science Center at San Antonio.

San Antonio allergist **Dale Wood, MD,** received the National Jewish Medical and Research Center's Spirit of Achievement Award.

Deaths

Barton Elmore Freeman, MD, 58; Amarillo; The University of Texas Medical School at San Antonio, 1970; died March 30, 1999.

Keith W. Kesling, DO, 43; San Antonio; Chicago College of Osteopathic Medicine, 1983; died March 12, 1999.

Dean Carl Kipp, MD, 80; Dallas; University of Kansas School of Medicine, 1943; died March 1, 1999.

James Edwin Marr, MD, 72; Bridgeport; The University of Texas Medical Branch at Galveston, 1960; died March 3, 1999.

Rodger Allen Moon, MD, 84; San Antonio; University of Kansas School of Medicine, 1939; died April 2, 1999.

John W. Pate, MD, 82; Alpine; Baylor College of Medicine-Dallas, 1940; died March 4, 1999.

Larry Henry Patton, MD, 60; Richardson; University of Tennessee College of Medicine in Memphis, 1963; died April 11, 1999.

Daniel Wayne Peterson, MD, 56; Fort Worth; University of Kansas School of Medicine, 1969; died March 21, 1999.

Robert Allen Scott, MD, 67; Dallas; The University of Texas Medical Branch at Galveston, 1956; died April 8, 1999.

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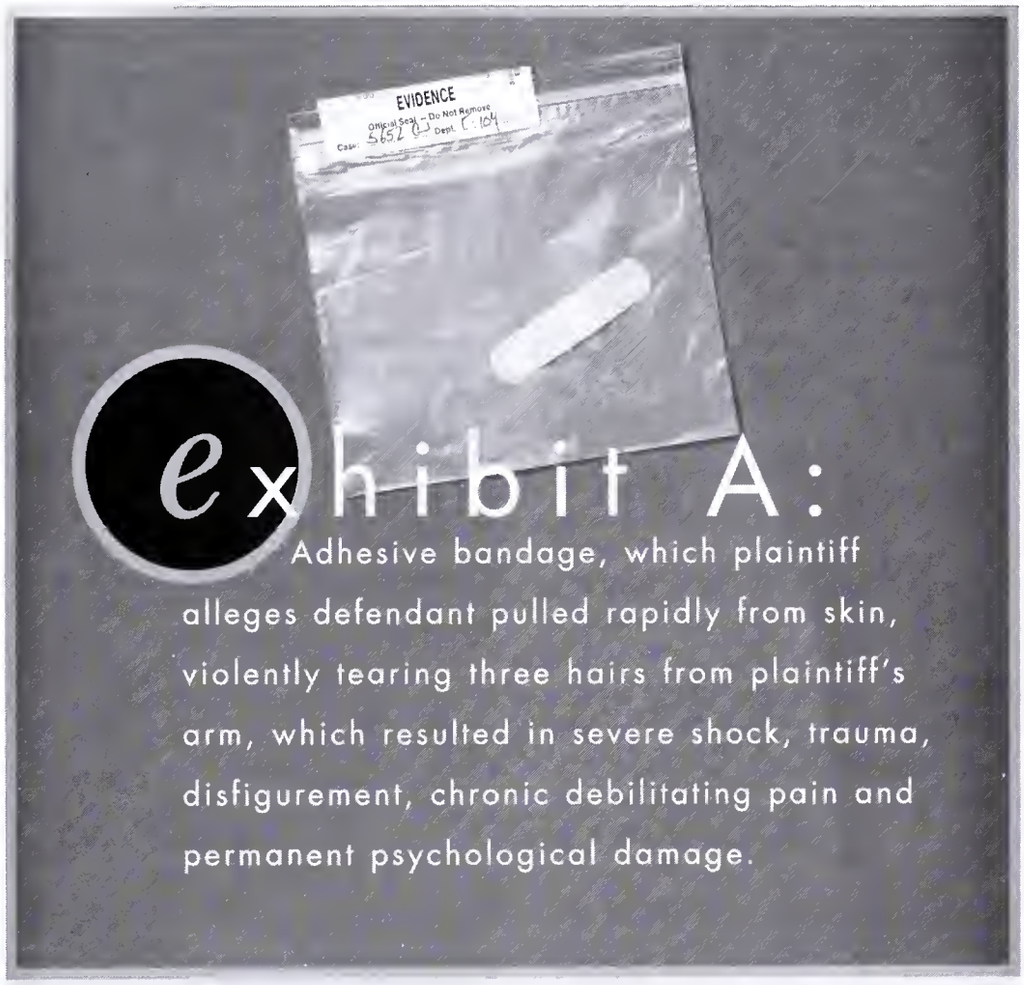

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Texas Medicine Rounds

By Johanna Franke

Changing of the guard

Dr Baum continues lengthy record of service with TMA presidency

You can't accuse Alan C. Baum, MD, of not taking full advantage of the opportunities presented by organized medicine. Look at some of the Houston ophthalmologist's activities since he began practicing medicine in 1973: chair of the Texas Medical Association Board of Trustees. Chair of the Committee on Liaison with Medical Schools. TEXPAC chair. President of the Texas Ophthalmological Association. President of the Southwest Branch of the Harris County Medical Society. Chair of the Harris County Medical Society Medical Legislative Board and Council of Specialty Societies. Chief of staff at Memorial Southeast Hospital in Houston and chair of the ophthalmology sections of both Memorial Southwest and Memorial Southeast hospitals. In his spare time, he is an assistant clinical instructor at The University of Texas-Houston Medical School and partner in the Texas Eye Institute.

And, as of May 7, Dr Baum is the new president of TMA, taking office during TexMed '99 in Dallas.

The obvious question is, why? Running a successful medical practice keeps a physician pretty busy, so why devote so much time to organized medicine? Dr Baum, 57, says the answer may be in the presentation on generational differences made by author and consultant Marilyn Moats Kennedy during the TMA Winter Leadership Conference in February. "She says I'm born in that generation of people who believe in joining and participating, and that by being a participant and being involved, you can try to change things and make things better."

Also influencing his propensity for participation is the same man who influenced him in becoming a physician — his father, Austin family practitioner Elmer C. Baum, DO. "I think it also has to do with the people you are around," said the younger Dr Baum. "I go back to my dad. My dad was the president of the Texas Osteopathic Medical Association and he's been very involved in its national legislative effort for years," he

said, adding that his father also served on the Texas Board of Health and the State Banking Commission. "Growing up in Austin, I've personally known probably a half-dozen governors. I think I've just been accustomed to seeing people involved in service to try to improve upon and represent the profession of medicine in the best way possible."

One of his goals as TMA president, he says, is to show young physicians the advantages of participating in organized medicine. "We are always looking for bright new stars. I'll encourage them to take up the charge because it's going to impact their lives more so than it is mine. I've been in practice 25 years and have enjoyed what many people refer to as the 'Golden Era of Medicine' where doctors were respected and the patient-physician relationship was everything."

we're in the process of trying to identify those areas." TMA will be very active "in the traditional role of trying to improve the health for those people who, for whatever reason, need help."

Also receiving his attention will be TMA advocacy efforts for its members and keeping TMA on top of issues that are important to physicians, such as relief from federal antitrust regulations and federal Employee Retirement Income Security Act exemptions that shield many managed care plans from liability lawsuits. What form that takes, he says, depends on actions taken by Congress, the Texas Legislature, and regulatory agencies.

A survivor of the attempt to mediate the battle between academic and private physicians in the so-called "town/gown" dispute in Galveston, Dr Baum says it is in TMA's interest to ease tensions between the two groups because it has

"There's got to be new people to come along and define the professional role of physicians in the health care delivery system."

Medicine is still a very rewarding profession, he said, "but there's got to be new people to come along and define the professional role of physicians in the health care delivery system. There needs to be bright people to look ahead and represent the new direction that medicine might take."

Dr Baum, who received his medical degree from The University of Texas Medical Branch at Galveston, says public health will be his main priority as TMA president. "The medical association needs to be involved in those issues in which the public health is involved."

He notes that TMA has initiated a series of meetings with Texas health commissioner William R. Archer, MD, and other state health officials "to find those areas where TMA with its 36,000 members can positively impact programs and provide input to the state board of health in a working partnership. Where that will lead us, whether we can be most helpful in school health or border health or wherever, we don't know. But

members on both sides. "We need to get as much funding as possible for the medical schools so they are not having to compete against the community-based physicians, and then we have to look for ways the community-based physicians and the academic physicians can mutually involve themselves so that it's not a conflict, but an effort together."

Dr Baum has mastered participation in organized medicine, but there's one area where he needs improvement. "I would love to be a golfer," he said. "My problem is that I don't have enough ego to be a golfer. By the time I finish the first couple of holes, I question why I'm there."

Thus, he finds much more pleasure in hunting and fishing and spending time with his 18-year-old son and 14-year-old daughter. "They're great kids," he said. "They work very diligently as students, but they do have to work for what they are able to accomplish. They have a great sense of honesty and what's right and wrong, and I'm very proud of them." ★

Hendricks leads TMAA into 21st century

Pam Hendricks, who was installed as president of the Texas Medical Association Alliance (TMAA) during TexMed '99 last month, is ready to apply lessons learned in the past to build a better future for TMAA and the health of Texans.

During her term as president, Ms Hendricks, of Temple, will work with TMA physicians and staff to develop a statewide cardiovascular disease awareness and education project. She also will implement many of the proposals featured in the Medical Alliance 2000 study to enhance TMAA's value to TMA.

Ms Hendricks will emphasize recruitment and involvement of more members, especially young spouses just beginning their lives in medical families, and TMAA members with limited time available for medical alliance activities because of outside professions. "Now, more than ever, we need to utilize the talents and strengths of the broad range of physicians' spouses in Texas, male and female, and of all races, ages, and interests," she said.

Lastly, Ms Hendricks says she hopes to demonstrate to TMA members, through council and committee participation, that TMAA members are able and willing partners with much to contribute to organized medicine's efforts. "I am confident that, working together, we can enter the new millennium more united, more inclusive, and more committed than ever to preserve the integrity of medicine for the future." ★

MedBytes

June's "MedBytes" focuses on the growing number of Web sites dedicated to the study of genetics.

The human connection

The US Department of Energy funds the Human Genome Program, located at www.er.doe.gov/production/ober/hug_top.html. The site includes hundreds of links as well as a "Frequently Asked Questions" section. The Human Genome Project site at www.ornl.gov/hgmis/resource/medicine.html is designed to help physicians, nurses, genetics counselors, and other medical personnel keep up on the latest information in genomic medicine, though it should not be considered a medical authority. The project is sponsored in the United States by the Department of Energy and the National Institutes of Health (NIH). NIH also oversees The National Human Genome Research Institute, which heads the Human Genome Project and has a Web site at www.nhgri.nih.gov/About_NHGRI/.

Genetic disorders directory

GeneTests, at www.genetests.org, offers a directory of laboratories that provide testing for genetic disorders. Both research and diagnostic laboratories are included and are classified by disease name. The site is restricted to health care professionals, who must register with GeneTests to receive a password.

Inherited information

GeneClinics, located at www.geneclinics.org, was formally known as Genline and complements GeneTests with a knowledge base of expert-authored, up-to-date information relating genetic testing to the diagnosis, management, and counseling of individuals and families with inherited disorders.

Genetic glossary

The National Human Genome Research Institute's "talking glossary of genetics" features nearly 200 terms and helps people better understand genetic concepts associated with recent advances in genetics. Located at www.nhgri.nih.gov/DIR/VIP/Glossary/, the glossary is open to the public and combines text, audio, and visuals simultaneously in a user-friendly format.

Card carriers

GeneCards' online database of human genes, their products, and their involvement in diseases is located at bioinfo.weizmann.ac.il/cards/. The database is especially useful for those who are searching for information about large sets of genes or proteins.

Online genetic newsletter

The Shriver Center has received a grant from the US Department of Energy to develop and generate an electronic newsletter about genetics ethics and public policy. *The Gene Letter* is located at www.geneletter.org/index.htm.

TMA's Cyber Sweepstakes celebrates summertime

Be sure to drop by the TMA Web site at www.texmed.org before June 30 to sign up for TMA's summer Cyber Sweepstakes. TMA members who provide or confirm their e-mail addresses through the "Members Only" section before the end of this month are automatically entered to win a Kodak DC210 digital camera with compact flash. Your e-mail address will be used to contact you with breaking health care news.

MedBytes is a quick look at new, or newly discovered, Web sites of interest to Texas physicians. The column also highlights features of the TMA Web site at www.texmed.org. If you know of some cool medical sites or have questions about how to use the TMA Web site, e-mail johanna_f@texmed.org. Publication of information about Web sites in this column is not to be considered an endorsement or approval by the Texas Medical Association of the sites or sponsors, or of any products or services involved.

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You'll shoot your eye out

Seven of 11 people who removed protective shields during paintball games became legally blind in one eye, according to study results published recently by the Associated Press.

Though most paintball game centers insist on eye protection, players are tempted to remove their shields after a paintball lands on a lens or their goggles fog up, says Lt Col Allen B. Thach, MD, the ophthalmologist at Walter Reed Army Medical Center who conducted the study. This exposes the eye to the impact of a missile of gelatin-enclosed paint fired from a carbon dioxide-powered gun at 300 to 400 feet per second, Dr Thach says. ★

Transitions: Legal Considerations in Selling or Closing a Medical Practice

by Hugh M. Barton, JD

If you are retiring, selling your practice, or joining a new practice setting, you will want to read Texas Medical Association's newest Strategy Series publication.
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The Texas Medical Association Insurance Trust offers life, health, disability, office overhead, personal accident, and other insurance plans and products to TMA members, their families, and office staffs.

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Specialty Societies	ssms
TMA Alliance	tmaa
TMA Bookstore	bookstore
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NMA works to avert racism in medicine

On the heels of decreased medical school minority student enrollments and a Georgetown University Medical Center study that indicates minority cardiac patients are less likely than white males to receive appropriate treatment, National Medical Association (NMA) officials are offering suggestions to recognize and eliminate racism in medicine.

Leaders from NMA, which represents more than 20,000 African American physicians, made the following recommendations at a March 31 press conference:

- Make medical school curriculum changes so medical students are exposed to racial and gender health issues.
- Increase the number of African Americans in medical school.
- Expand the number of African American researchers and peer reviewers in all levels of biomedical research.
- Elevate the National Institutes of Health's Office of Research on Minority Health to that of a center.
- Conduct a congressional study on racism in medicine. ★

Scott & White nets funds for telehealth network

The Texas Telecommunications Fund Board presented two grants totaling $894,629 to Scott & White Memorial Hospital to establish the Central Texas Telehealth Network. The network will help provide specialty patient consultations, patient and community education, and health care provider education in rural settings.

The network includes hospitals and affiliated rural health clinics in Marlin, Gatesville, Taylor, Rockdale, and Clifton, as well as Scott & White. The hospitals will contribute $123,461 in matching funds. ★

TMA committee addresses academic physician needs

The Texas Medical Association Board of Trustees formed a Committee for Academic Physicians as a subcommittee to the Council on Medical Education.

Subcommittee members will be recruited from below the level of dean to ensure that the interests of academic physicians at the grassroots level are represented. Initially, the subcommittee will address TMA membership among academic physicians, issues concerning academic practice, and ancillary provider integration into the academic practice setting.

For more information on the new subcommittee, call Marcia Collins at (800) 880-1300, ext 1451, or (512) 370-1451; or e-mail marcia_c@texmed.org. ★

Physicians needed for editorial committee

Two physicians are needed to fill vacancies on the *Texas Medicine* Editorial Committee. The 14-member committee, which meets twice a year, sets broad policies for *Texas Medicine* and reviews clinical articles submitted for publication in the Journal section of the magazine.

Each new member will serve a 3-year term and be eligible for reappointment to two additional 3-year terms. If you are interested, please send a curriculum vitae to Larry BeSaw, managing editor, *Texas Medicine*, 401 W 15th St, Austin, TX 78701; fax (512) 370-1632; or e-mail larry_b@texmed.org.

Editorial Committee members are appointed by and report to the TMA Board of Trustees.

SUMMARIES OF RECENT HEALTH CARE HEADLINES

In Case You Missed It

By Melissa McEver

A certain kind of bone marrow cell can actually grow new bone and cartilage, researchers have found. Scientists at OSIRIS THERAPEUTICS in Baltimore concluded that a mesenchymal bone marrow stem cell could be induced to create possible replacement bone, cartilage, or fat. This discovery is a step toward creating replacement parts for the injured, sick, or elderly.
***Science*, 4/2/99**

Night vision may not be as accurate as initially believed. German researchers found in a study of red-green colorblind men that the eye's rod cells, which work in dim light, perceive objects to move 75% slower than cone cells, which work in bright light. The artificial illumination of headlights corrects a driver's view in front, but peripheral vision still is affected by this inaccurate perception.
***Nature*, 4/8/99**

Sudden cardiac death may run in families, a new study indicates. Scientists at the SERVICE DE CARDIOLOGIE AT THE HOPITAL BOUCICAUT in Paris found that men who lost one parent to sudden cardiac death had almost double the risk of sudden death than men with no such parental history. The study followed 7,079 Parisian men for about 23 years.
***Circulation*, 4/20/99**

Taking estrogen just might improve the memories of postmenopausal women. YALE UNIVERSITY SCHOOL OF MEDICINE researchers found that the brains of postmenopausal women taking estrogen showed more activity in the memory regions than did the brains of women taking a placebo. The estrogen-prompted neural connections resembled those of younger people, the authors concluded.
***British Medical Journal*, 4/17/99**

A school-based intervention program shows promise in reducing obesity in girls. A group of American experts reported that Planet Health, a program encouraging boys and girls to watch less television, eat less fatty food and more fruits and vegetables, and exercise regularly significantly reduced obesity in girls at a Massachusetts elementary school. The impact on boys was less significant.
***Archives of Pediatrics & Adolescent Medicine*, 4/99**

BEFORE YOU SIGN

Contract TIPS

Things you need to know

Austin attorney mediator Andre Hampton, JD, and the TMA Office of the General Counsel suggest an ideal managed care contract should:

- **Say that neither party can unilaterally amend the contract, any related documents, or the fee schedule; or terminate the contract without cause, which is defined in a manner that is fair to both parties.**
- **Allow you to bill patients (unless prohibited by law) when the managed care organization or the payer fails or is unable to pay; when services are not covered by the contract; and when you have advised the patient that the managed care organization or payer has determined that proposed services are not medically necessary.**
- **Incorporate any oral or written representations and verbal representations that the managed care organization made to you about the plan and its operation.**

Source: TMA Physician Services. For more information about TMA Physician Services or to request a copy of the catalog, call (800) 523-8776 or (512) 370-1418; or e-mail physician_services@texmed.org.

Most medical students meet their matches

Primary care residency matches were down, but nearly 94% of US medical school seniors who participated in the 1999 match on March 18 received first-year residency training positions, according to data from the National Resident Matching Program. Approximately 57% of these seniors matched to their first choices for first-year programs, while nearly 81% matched to one of their first three choices for first- and second-year programs.

A total of 20,453 first-year residency positions were offered this year, an increase of more than 150 positions from last year. Participation in the match program also was up slightly this year, increasing from 26,360 students in 1998 to 26,462 students this year. Of that, 18,398 were matched to first-year residency programs. For the first time, the combined number of first- and second-year matches exceeded 20,000, with 20,170 participants receiving residency positions.

Fewer US medical school seniors matched in primary care residencies this year than in the previous 6 years, according to an April 5 *AMNews* article. Of the 13,707 US medical school seniors selected for first-year residencies, nearly 54% were matched to primary care residencies in internal medicine, family practice, and pediatrics. Last year, 55.7% matched to a first-year residency in primary care.

Of the 7,977 non-US citizen international medical school graduates who participated this year, 32.2% were matched, up from 31.4% in 1998. ★

Susan Gaetz

Dolores Sands, PhD, RN, dean of The University of Texas at Austin School of Nursing, and Robert F. Ellzey, MD, of Austin, a member of the nursing school's development board, examine a bust of Florence Nightingale, the founder of modern nursing, during the "Florence Nightingale and Her Legacy for Nursing" exhibit at the LBJ Library in Austin. The bust was made especially for the exhibit and was featured along with more than 30 items loaned for the exhibit by the Florence Nightingale Museum Trust in London. Byron Howard, MD, former chair of the Texas Medical Association Board of Trustees, calls the exhibit a great opportunity for the health care community to benefit from history. TMA contributed $2,500 to help underwrite the expense of bringing the artifacts to the United States, signifying the first time they have been loaned to any US institution.

Teachers pass on dislike of HMOs to students

Medical students' and residents' negative perceptions of managed care are strongly influenced by their teachers, according to a study sponsored by Harvard Medical School and Harvard Pilgrim Health Care, a large nonprofit health maintenance organization.

Nearly 75% of students and residents surveyed said primary care faculty members gave them negative opinions of managed care, while 96% said specialty faculty members gave them negative impressions.

The study was based on 1997 telephone interviews with more than 2,000 people affiliated with 121 US medical schools, including medical students, residents, faculty members, deans, department heads, and residency training directors. ★

Mark your calendars for the next TMA meeting

Start making plans now to attend Texas Medical Association's 1999 Fall Conference: Turning Points in Medicine, Saturday, September 18, at the Renaissance Austin Hotel.

Conference speakers will include American Medical Association President Thomas R. Reardon, MD, Portland, Ore, and TMA President Alan C. Baum, MD, Houston. Meeting participants also may attend the "dawn duster" session and an afternoon risk management seminar titled "Was It Something I Said? The Underlying Psychology of Medical Malpractice Litigation."

Registration is free for TMA members and invited guests, and $200 for nonmember physicians. For more information, call Amy Edwards, TMA special services, at (800) 880-1300, ext 1346, or (512) 370-1346; or e-mail amy_e@texmed.org. ★

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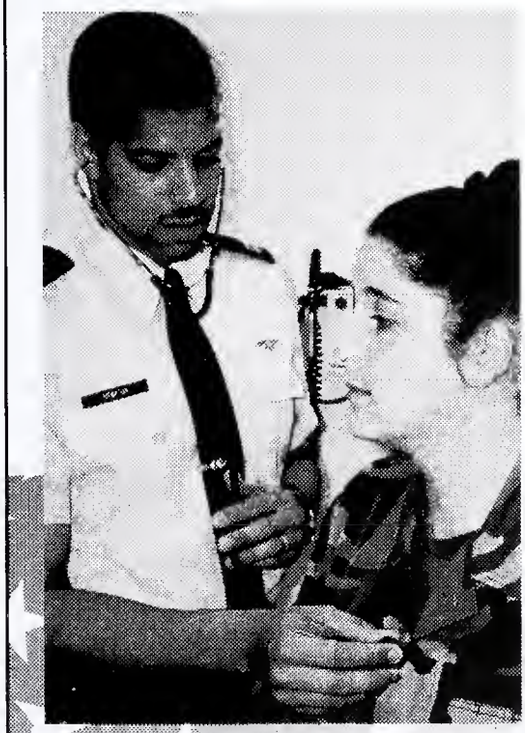

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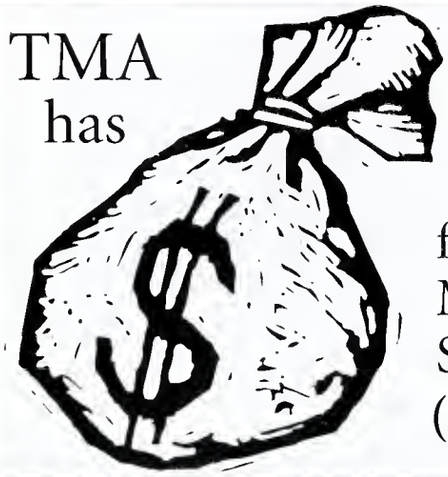

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Some pacemaker batteries may not pace themselves

Reuters reported in April that Guidant, the Indianapolis-based cardiovascular devices manufacturer, warned physicians in late March that a subset of its Discovery, Meridian, and Pulsar pacemakers have the potential for early battery depletion. As of March 31, no deaths or serious injuries in patients with these pacemakers had been observed, according to a Guidant press release.

Though Guidant said the problem affects a very small subset of implanted pacemaker devices and continued its regular distribution of these pacemakers, company officials told physicians they should monitor patients with these types of pacemakers on a monthly basis for up to 6 months for signs of early battery depletion. ★

Empowerment improves patient satisfaction

Patients are more satisfied when health care organizations explain their rights to them, according to study results released by Press, Ganey Associates, Inc, in April. The survey of a quarter of a million patients in 476 hospitals asked participants whether hospitals took the initiative to inform and explain patients' rights to them.

The mean satisfaction score was 84.9 for patients who had received information regarding their rights. The overall satisfaction mean was 81.2 for those patients who had not been informed.

The American Hospital Association (AHA) developed the Patient Bill of Rights in 1973 to contribute to more effective patient care and greater patient satisfaction. Health care organizations do not have to use the AHA Bill of Rights, which states a patient has a right to respectful care, understandable information regarding diagnosis, and confidentiality. ★

Forum On Ethics

Where is the outrage? An open letter to the Speaker of the TMA House of Delegates

By John R. Pettigrove, MD

The idea for this Forum on Ethics was developed because the leadership of the Texas Medical Association has a sense that something is going terribly wrong. The success of both Medicare and managed care depends upon skillful control of the providers' behavior, and it is how we as physicians are reacting to the demands of this fiscal change that is being called into question.

Today it would appear that my practice is less dependent on my professional skills and more dependent on my ability to adapt to change than any other time since I began as a solo internist some 25 years ago. Each year, it has become a little tougher to satisfy the third-party payers without a sense that I am betraying the standards of my profession and the people who come to me seeking medical help. In a nutshell, it would appear that I have a choice: I can be a good internist, or I can be financially prosperous. Each day that goes by seems to increase the disparity between what is good medical practice and what is financially expedient.

You who are ardent supporters of managed care feel sure that my view is all wrong. Before you dismiss me as just another mad-dog reactionary who fears and despises progress, please hear me out. I agree. Economic prudence and good medical practice go side by side. But I hardly see it happening. What I do see is blatant self interest guiding the decisions that govern how health care is financed, regulated, and dispensed. Self-interest has become a virtue, perhaps the only present-day virtue. Today, colleagues whose nefarious schemes would have been the objects of professional scorn years ago are roundly applauded for their ingenuity. The human genome is up for patent and sale. I, for one, would like to see a change.

But change is not the point of this essay. My point is a question, and my question is, what is the moral and ethical basis of our profession?

We physicians are considered among the most educated in our society. Our social and professional responsibilities require us not only to understand the complexities of medical science, but it is exigent that we also understand the convolutions of our culture. Medicine by its very nature is a moral science. We physicians are not dispassionate bystanders. We are active players, and our effectiveness is defined by how earnestly we pursue our art.

Requisite to being educated is understanding the basis of our moral and philosophic beliefs. Unfortunately, when it comes to our own traditions, we are an ignorant people. The ethical basis of our civilization is heavily rooted in the Bible and Western philosophy. So the great works of Western philosophy have defined and redefined our character over centuries, and it is up to us to decide what facets of that character we wish to reveal to the world during our own lifetimes. We live in an age so lopsidedly obsessed with materialism and subsequent dualism that the notion of idealism and its extant virtues has become little more than a dead metaphor for times past.

What has gone wrong, Dr Speaker, is that the traditional values that have forged our professional character have come foursquare against a changing society, a society that is rapidly losing its way. It is not our responsibility to accommodate it. It is our responsibility to heal it and to guide it back toward the platonic and Biblical ideal. We may never be ruled by a philosopher king, but God help us if we come to be ruled by a Cesare Borgia.

What has gone wrong, Dr Speaker, is the death of outrage among our colleagues.

John R. Pettigrove, MD, is a physician in Corpus Christi and a member of the *Texas Medicine* Editorial Committee.

Texas Medicine welcomes comments about issues discussed in the Forum on Ethics. If you would like to comment or submit a column for possible publication, please contact Teri Moran, senior editor, at *Texas Medicine*, 401 W 15th St, Austin, TX 78701; phone (800) 880-1300, ext 1371, or (512) 370-1371; fax (512) 370-1632; or e-mail teri_m@texmed.org. Proposed columns must be no longer than 900 words and written in a case study format.

Medicare's new army

HCFA enlists physicians and patients in its fight against fraud and abuse

AJ Garces

Most Texas physicians have never and will never intentionally defraud a health insurance provider, and most resent being painted as criminals. But just keeping their noses clean is no longer enough. New initiatives demand that physicians police each other and medical service providers. Oh, and now, Medicare is enlisting patients. ➤➤

By Monica Maldonado, Associate editor

But at least the Health Care Financing Administration (HCFA) is beginning to tone down its rhetoric, much to the relief of physicians who had always felt wrongly accused, as it continues its well-funded, relentless pursuit of Medicare crooks. At the Second Annual National Congress on Health Care Compliance, government officials spoke in more temperate language of common goals between HCFA and physicians for weeding out fraud.

There may be two reasons for HCFA's attitude change. One is that a recent audit of Medicare by the Department of Health and Human Services (HHS) Office of Inspector General (OIG) revealed a significant drop in documentation errors since 1996, when the office first began performing audits. At least part of that drop can be attributed to physicians' participation in the audit. In the past, many physicians who had been audited were not submitting requested documentation, which prompts the OIG to qualify the case as an error. And the second reason may be that HCFA now wants doctors to scout swindlers for them.

The results of the 1998 audit by the OIG were heralded as good news among the forces fighting fraud and abuse. Compared with previous years, the estimated $12.6 billion of improperly paid funds for fiscal year 1998 is indeed an improvement. The estimate represents a 7.1% error rate, down from 1997's 11% rate ($20.3 billion) and 1996's 14% rate ($23.2 billion). HHS Secretary Donna Shalala credits the decline in error-loss dollars to the federal government's zero-tolerance policy on waste, fraud, and abuse, but this connection is a bit tenuous.

The OIG identified two major problem areas — payments for services that were not medically necessary and bills that were upcoded to receive higher reimbursement rates than were justified — which account for $9.3 billion of the improper claims. The other improper claims were attributed to documentation discrepancies, services not covered by Medicare, and other types of errors. According to the OIG, only 26% of improper bills were submitted by physicians while hospitals, home health agencies, nursing facilities, and durable medical equipment (DME) suppliers, among others, accounted for the rest. But the 7.1% error rate includes everything from inadvertent mistakes to outright fraud, and the OIG admits that quantifying the amount directly attributable to fraud, much less fraud by physicians, would be impossible.

It's not you, it's them

Regardless, HCFA has not softened its stance on fraud and abuse. It does seem, however, to be focusing on the biggest culprits. Recently, HHS Inspector General June Gibbs Brown issued a fraud alert warning against "physician laxity." The alert said most physicians do not intend to defraud Medicare when they authorize home health care and durable medical equipment (DME) for a patient, but physicians do need to be more careful and emphatic in assessing medical necessity or reviewing forms from the medical service provider before signing them.

The alert cautioned against prescribing these services as a courtesy without determining medical necessity, knowingly or recklessly signing false or misleading medical certification, and accepting kickbacks for their signatures. "We are issuing this Fraud Alert because physicians may not appreciate the legal and programmatic significance of certifications they make in connection with the ordering of certain items and services for their Medicare payments," the OIG said. "We urge physicians and their staff to report any suspicious activity in connection with the solicitation or completion of certifications to the Office of Inspector General."

Steven Dunnagan, MD, a member of TMA's Board of Councilors, believes most physicians should concede to HCFA on the point that physicians are responsible for weeding out fraud in cases where their signatures are required. "It may sound simple-minded to say, but I think Texas physicians ought to take command and demonstrate an intolerance for these people who operate on poor motives," said Dr Dunnagan. "If we don't take this upon ourselves, somebody is going to do it for us," he added. "That's kind of what is happening now, and so far it has been very painful."

Facing the Medicare bullies

Dr Dunnagan calls HCFA's methods "Machiavellian" and says they "make the IRS look like choirboys." Among the weapons HCFA wields is the False Claims Act, a law dating back to 1863 that allows private citizens — acting as *qui tam* or whistle-blowers — to prosecute defrauders for a portion of the proceeds. The number of *qui tam* cases grew from 33 in 1987 to 532 in 1997, and by September of 1998, 60% of *qui tam* cases involved HHS. The legal community predicts that whistle-blowing will be even more widespread in the coming years.

Some say that the continued, creative use of the False Claims Act distorts health care regulations. When a whistle-blower calls a health care provider on a claim, for instance, it is often in the best interest of the provider to settle out of court. Penalties for each false claim can be $5,000 to $10,000; at the same time, the burden of proof was relaxed from "clear and convincing evidence" to a "preponderance of evidence." In addition, there is little to discourage frivolous lawsuits.

All of this can seem pretty scary to physicians who wonder if their honest mistakes will be penalized under this

"It may sound simple-minded to say, but I think Texas physicians ought to take command and demonstrate an intolerance for these people who operate on poor motives. If we don't take this upon ourselves, somebody is going to do it for us."

Legal articles in *Texas Medicine* are intended to help physicians understand the law by providing legal information on selected topics. These articles are published with the understanding that TMA is not engaged in providing legal advice. When dealing with specific legal matters, readers should seek assistance from their attorneys.

law. But the percentage of physicians who are taken to court under the False Claims Act is very small, says Assistant US Attorney Pete Winn, JD. "Ninety-five percent of these cases are dismissed if the government doesn't intervene, and 95% are settled out of court when the government does intervene. *Qui tam* is a threat, but that threat can be dramatically reduced if the doctor is clear and communicates well with his or her billings person."

Aside from the possibility of costly and damaging litigation, another thing that frightens physicians is audits, especially postpayment audits, says Barry Thomas, a Part B medical review coordinator for TrailBlazer Health Enterprises, Inc — the Texas Medicare carrier.

HCFA has drafted some new guidelines for its Medicare carriers that would slightly increase the number of postpayment audits being performed. Exactly how much that percentage will be increased will be finalized this summer. Mr Thomas says that, though the percentage by which postpayment audits will be increased is much less than 1%, even an incremental increase will greatly affect a carrier as large as TrailBlazer. Between October 1998 and March 1999, TrailBlazer conducted 2,070 postpayment audits, the results of which range from the determination of no improper payment to the imposition of heavy fines, with many of the cases still pending. But that number includes all of the places for which TrailBlazer acts as a carrier, including Maryland, Delaware, Washington, DC, and Texas.

Mr Thomas says that if that amount is the same in the next 6 months, then over a year, the agency will have conducted 4,150 postpayment audits out of an estimated 55 million claims, resulting in a postpayment audit rate of less than 1 out of 10,000. "The bulk of these are physician claims," Mr Thomas said, "but that number also includes ambulance service providers, therapists, and others."

Dr Dunnagan says his staff's experience with postpayment audits and HCFA has not been bad. He remembers one instance where HCFA simply pointed out what was wrong and requested that the overcharges be paid back without a fine.

Barbara Harvey, vice president of Medicare Program Integrity in Texas, says most of her efforts focus on preventing improper payments in the first place. She agrees with the assessment that the number of physicians guilty of fraud in this state is relatively small. But, she added, "The message we want to convey is that physicians need to be cognizant of the rules and understand the policies regarding billing."

- To the best of your knowledge, is the service or product relevant to your diagnosis or treatment?

AARP also urges its members to call the fraud hotline if they "can't easily resolve their questions with the provider."

Most physicians are outraged by the program, saying that nothing could damage the patient-physician relationship more.

> "The message we want to convey is that physicians need to be cognizant of the rules and understand the policies regarding billing."

The latest threat

Almost everyone agrees that most physicians don't have anything to worry about when it comes to being prosecuted for fraud. Honest mistakes are just that. The line between them and outright fraud is usually very clear, and despite the threatening overtones from HCFA, most of the time the Medicare carrier will work with physicians to correct their billing procedures. Still, physicians' resentment against interference from health insurance providers exists.

Now, a new initiative has been added to the list of fraud watchdogs, further undermining physicians' sense of privacy and cutting into their relationships with their patients.

HHS and the US Department of Justice have teamed with the American Association of Retired Persons (AARP) to create a program that encourages Medicare beneficiaries to keep an eye out for incorrect billing by their health care providers. Called the "Neighborhood Fraud Watch," the AARP asked its members to be the "first line of defense" against Medicare fraud. On its Web site, the AARP advises members to call the fraud hotline if they respond "no" to any of the following questions:

- Did you receive the service or product for which Medicare is being billed?
- Did your doctor order it for you?

"The government's tactics are lamentable," said American Medical Association President Nancy W. Dickey, MD, of College Station. "The government simply does not know the split of the Medicare payment problem between genuine fraud and unintentional billing errors caused by the hideously complex, incomprehensible government forms."

Sage advice

In the end, all this culminates to a single preventive measure: be honest. Mr Winn says doctors have been scared unnecessarily. The picture being painted by HCFA and other agencies that improper payment errors and fraud and abuse of Medicare are scourging the system is a bit misleading because "if you apply only 10% of the resources you need to deal with the problem, you're always going to have a problem." Also, he believes that defense lawyers who are interested in representing doctors may purposefully overstate the actual risks to doctors.

Dr Dunnagan's attorneys have said that the best way for physicians to avoid audits is to review and update their procedures. If they believe they might be making mistakes in coding procedures, they should not call attention to the mistakes made in the past but correct future errors. ★

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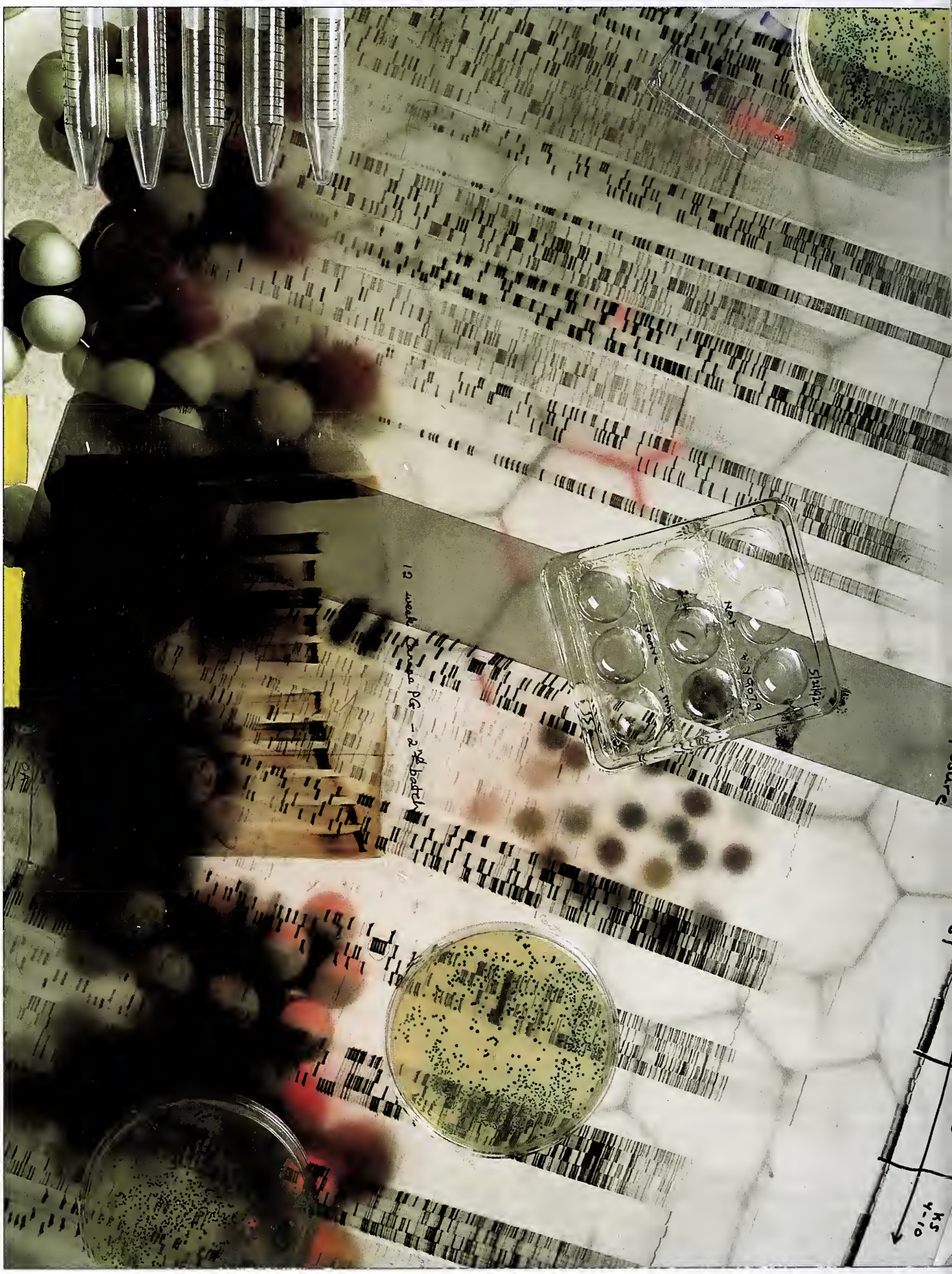
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Wading in the gene pool

Genetics research has great potential, but do physicians know how to use it?

By Monica Maldonado, Associate editor

In 1995, Francis Collins, MD, now director of the National Institutes of Health Human Genome Research Institute, predicted, "Ten years from now, almost every doctor will be dealing with DNA tests in their offices. We must move swiftly to be prepared for the revolutionary change in the way medicine will be practiced." Four years later, exactly how and what to prepare for remain to be seen. ➤➤

The exponentially growing knowledge of the human genome is creating seemingly limitless possibilities for medicine. With the accelerated rate of discovery come questions most have never contemplated. Inevitably, the public will look to physicians for answers while physicians themselves struggle to find accurate information. "Genetics is a powerful science," said Jenny Young Tribble, program manager of TMA's Physician Oncology Education Program (POEP), "but there is work to be done before it will empower most practicing physicians."

Physicians are being confronted by patients with a little information and a lot of questions about genetic screening, specifically the new DNA tests. Today, physicians new to the field can turn to genetics professionals, including board-certified genetics counselors who are trained in discussing risk and outcome. So far, however, Texas has only approximately 40 genetics counselors, not all of whom are practicing. Jill Cortada, RN, a genetics counselor at The University of Texas Health Science Center (UTHSC) in San Antonio said, "I know of three genetics counselors in San Antonio, but I'm probably the only one working. And I work part-time."

If Dr Collins' prediction comes true, will physicians be ready to take on their new roles as genetics liaisons? It's difficult to see past the obstacles. Many doctors stop short of referring patients for genetic testing, concerned about the high costs of the new tests and the privacy of the results, as well as the uncertainties of dealing with patients when the test results are available. Other hurdles to consider include the availability of genetic testing and the risk of discrimination and social stigmatization for those who have been determined to be disposed genetically to a particular disease, not to mention the current lack of available medical options for treating untreatable diseases.

In 1996, POEP surveyed Texas physicians to gauge their experiences with genetic cancer screening. Although the results are 3 years old, one of the survey's developers, Sharon E. Plon, MD, PhD, director of the Baylor Cancer Genetics Clinic at Texas Children's Hospital and Methodist Hospital, both in Houston, believes the results would not be much different if the same survey were to be conducted on the same physicians today.

"Physicians still feel a real gap between what's been discovered and what they know," Dr Plon said. She optimistically added, "But my experience has been that, like most things in clinical medicine, once physicians refer a few patients to a genetics clinic, they start to get a handle on what is useful and what isn't, and they get more comfortable with the process."

The obstacles physicians perceive

In order to integrate DNA testing into their standard practice, physicians must first learn the facts behind their preconceptions. Physicians' concerns about the cost of screenings is significant, in light of the growth of managed care and Medicaid cutbacks. So far, the feedback on the cost of the new genetic tests has been mixed. The most widely used genetic cancer tests have been the $2,400 BRCA1 and BRCA2 tests for breast and ovarian cancer, respectively. Ms Cortada says the majority of her patients are covered for the tests by their health insurance plans. The center also has a small amount of grant money available, which it uses to sponsor patients with no insurance and strong family histories for the diseases. And she's also seen patients who choose to pay for the procedure out-of-pocket, mostly to keep the results from their health insurance providers.

Physicians who responded to the POEP survey also said a major concern is the current lack of guidelines for appropriate surveillance and treatment for patients who have tested positive.

A facility in Salt Lake City owns the patent for the BRCA1 and BRCA2 tests, so all genetic samples in the United States are tested there. For the office visit and interpretation of the results, the UTHSC-San Antonio clinic charges patients from $200 to $400 per visit. As Ms Cortada explained, "Being worried about the cost is a legitimate concern, but the results of the test are not at all simple to interpret. A patient has to go to a clinic that has a lot of experience with these tests." She says at UTHSC-San Antonio, the test results are discussed by a team, which usually consists of three medical oncologists, a biostatistician, a genetics counselor, an ethicist, and sometimes a medical anthropologist, before they are offered to the patient.

Arthur Beaudet, MD, of the department of molecular and human genetics at Baylor College of Medicine and a past president of the American Society of Human Genetics (ASHG), also believes the concern over royalty fees from facilities that own patents might deter physicians from referring patients for tests. But looking forward, in a presidential address to the ASHG, Dr Beaudet compared adult DNA testing with the testing performed as part of newborn screening. "There may be an important threshold effect for population-based DNA testing, which perhaps awaits a single, compelling application to justify implementation." He continued, "If this were to occur, the cost of adding tests would be significantly reduced as the processes for consent, sample collection, and reporting could serve for multiple tests."

Physicians who responded to the POEP survey also said a major concern is the current lack of guidelines for appropriate surveillance and treatment for patients who have tested positive. For example, when a patient learns that her chances for someday having breast cancer are very high, or positive, she might turn to her physician for guidance on how to proceed, leading to a "What would you do, doctor?" scenario. But Ms Cortada says physicians do not have to go through it alone. Most genetics counselors continue their relationships with patients long after the test results are com-

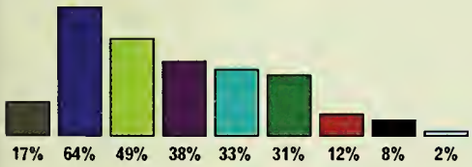
Survey of primary care physicians

Below are the results of the 1996 survey performed for the Texas Medical Association's Physician Oncology Education Program by the Baylor College of Medicine Center for Cancer Control Research, with funding from the Texas Cancer Council. A discussion of the results, by Lois C. Friedman, PhD; Sharon E. Plon, MD, PhD; H. Paul Cooper, MA; and Armin D. Weinberg, PhD, was published in the *Journal of Cancer Education* (1997;12:199-203).

Have you ever discussed with a patient the subject of genetic screening for susceptibility to any of the following cancers? (42% checked one or more)

- None of the following
- Breast cancer
- Ovarian cancer
- Colon cancer
- Gastric cancer
- Renal cancer
- Lung cancer
- Thyroid cancer
- Pancreatic cancer
- Brain cancer
- Other

Are there situations where you would consider genetic screening for any of the following disorders that predispose to cancer? (83% checked one or more)

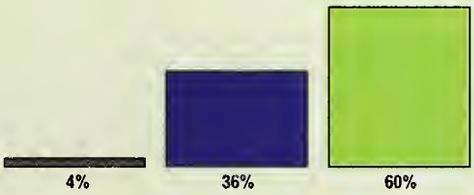


- None of the following
- Breast, ovarian cancer (BRCA1, BRCA2)
- Familial polyposis coli (Gardner's syndrome)
- Neurofibromatosis, types I or II
- Multiple endocrine neoplasia, type II
- Hereditary nonpolyposis colon cancer
- Von Hippel-Lindau disease
- Germline p53 mutation (Li-Fraumeni syndrome)
- Other

Have you ever referred a patient for genetic evaluation for cancer risk?

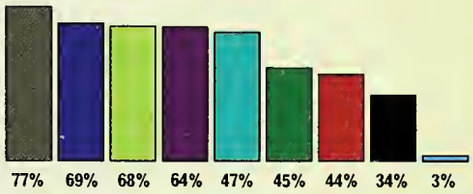
- Yes
- No, wanted to refer but such services were not available
- No, have had no need for such services

Have you ever requested DNA testing of a patient for cancer risks?



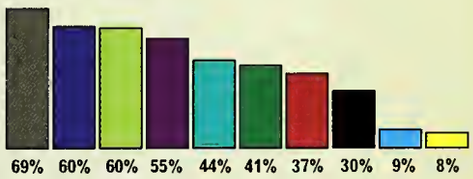
- Yes
- No, would have used such services were they available
- No, have had no need for such services

I would like to see more continuing education programs and educational materials on genetic testing for cancer risks covering the following subjects: (check all that apply)



- Genetics of breast cancer
- Cancer screening guidelines for patients at high genetic risk
- Genetics of colon cancer
- Genetics of ovarian cancer
- Legal issues
- Ethical issues
- Other cancer genetic syndromes
- Informed consent issues
- Other

Which of the following would you consider to be major obstacles to adopting greater use of genetic testing for cancer risks in your practice? (check all that apply)



- Cost of genetic testing
- Lack of guidelines for patient's reaction to test results
- Concern about impact of testing on patient's insurability
- Availability of genetic testing
- Potential for false-positive results
- Concern about patient's reaction to test results
- Difficulty in interpretation of test results
- Potential for false-negative results
- Other
- None of the above

pleted. "We continue to see them in our clinic every 6 months or annually, and in the case of breast cancer, we devise a list of recommendations for surveillance," she said.

Dr Plon predicts that more and more medical organizations will begin to develop clear guidelines for dealing with positive results of genetic testing. She notes that organizations such as the National Institutes of Health and the American Society of Clinical Oncologists already have begun to map out guidelines for physicians.

The American Medical Association Code of Medical Ethics also addresses a patient's right to privacy, another major concern of Texas physicians. At the state level, this year's legislative session saw a bill (SB 538) that would strengthen antidiscrimination provisions passed last session by expanding on the definition of "genetic information." The bill applies to discrimination from employers, labor organizations, employment agencies, group health insurance plans, and licensing authorities. It also contains provisions for the patient's right or refusal to know the results and the destruction of the sample of genetic material.

At press time, the bill had passed from the Senate floor on to the House of Representatives for a vote. Jill Aslakson, TMA's scientific affairs specialist, said, "We hope this bill will encourage reluctant patients to disclose important information about their family histories."

An important reality

While physicians' concerns are valid, Dr Plon points out a major obstacle that the survey respondents were not as concerned about — interpreting the results of genetic tests. For a geneticist, Dr Plon says, this is the biggest obstacle. Currently, the law states that the person who orders the test is responsible for interpreting the results. Until recently, most tests were ordered by geneticists and counselors, who are trained to interpret test results. As more genetic tests are ordered by physicians, Dr Plon says, the fear is that they will misinterpret test results because of their lack of training and experience in this field.

"Being worried about the cost is a legitimate concern, but the results of the test are not at all simple to interpret. A patient has to go to a clinic that has a lot of experience with these tests."

TMA Advantage: POEP resources

The Physician Oncology Education Program (POEP) offers programs and symposia for continuing medical education credit that include discussion on genetic cancer screening.

"Eliminating Cancer Pain in the 21st Century: What Clinicians Need to Know"
June 19 — Austin

"Breast, Cervix, and Skin Cancers: What Primary Care Physicians Need to Know"
June 24 — Midland

"Cancer Control in Northeast Texas: What Physicians Need to Know"
August 12 — Texarkana

"Cancer Control in Special Populations: What Primary Care Physicians Need to Know"
Date to be announced — Longview/Marshall; Greater Houston Area

"Cancer Control in East Texas: What Primary Care Physicians Need to Know"
Date to be announced — Nacogdoches

For more information on any of these programs, call (800) 880-1300, ext 1672, or (512) 370-1672.

Other valuable resources for information on genetic testing in the state include The Texas Genetic Network, Diana Rosas, director, (210) 567-5194; www.tdh.texas.gov/texgene/texgene.htm.

The Texas connection

With researchers in Germany, Japan, England, and the United States, the Human Genome Project, which formally began in 1990, had predicted a detailed map of the entire human genome by 2005. Today, a pared-down consortium expects to have completed a "working draft" of the genome by spring 2000.

To drive the project to warp speed, the National Institutes of Health National Human Genome Research Institute (NHGRI) in March awarded three research centers in the United States $81.6 million over the next 10 months. One of those research centers was Baylor College of Medicine's Human Genome Sequencing Center, headed by Richard A. Gibbs, PhD, which received $13.4 million.

The Baylor lab was established in 1996 as one of six large-scale sequencing pilot projects funded by NHGRI. The new full-scale phase puts Baylor in the company of sequencing groups at Washington University in St Louis ($33.3 million) and the Whitehead Institute for Biomedical Research in Cambridge, Mass ($34.9 million), both of which were part of the NHGRI grant. The US Department of Energy's Joint Genome Institute and the Wellcome Trust-funded Sanger Center in Cambridge, England, complete the team that will aim for the spring 2000 deadline.

"We're the smallest, but it's pretty good company for our lab," Dr Gibbs said. "Baylor has assertively put itself forward to provide the resources for us to build the genome center. It was a brave thing to do, and now it has been rewarded."

The lab was selected because it had completed 15 million bases of high-quality, finished sequence by December 1998. Since 1996, the lab has grown to include 94 employees, 14,000 square feet of space, and 21 sequencing machines, with more on the way, thanks to the new grant.

"The big impact part of the project will occur over the next year," said Dr Gibbs, "but that will be just the beginning." When the human genome is completed, the Baylor lab will move on to sequencing the genome of the mouse. "Comparing the two will be extremely informative," Dr Gibbs said.

The speed at which the DNA is being sequenced has been spurred on by private competition. Last year, Perkin Elmer of Norwalk, Conn, the company that built the most state-of-the-art sequencing machines, paired with sequencing maverick J. Craig Venter to create Celera Genomics, in Rockville, Md. It said it would sequence the human genome by 2001, about 4 years sooner than the federally sponsored Human Genome Project had promised. "We were a little bit taken aback by the assertive moves of Perkin Elmer," said Dr Gibbs, "and it made us rethink our strategy."

Instead of creating a high-quality, finished sequence of the entire genome, the consortium is choosing to create the "working draft" at the earlier date. The difference between a high-quality sequence and a working draft is one of time and resources. As Dr Gibbs explains, the sequencing process is not 100% accurate. The machine takes a chemically altered DNA sample that "displays" each of the four bases in different colors. It then reads these colors one after the other. But to get the most accurate reading, the same sample of DNA is put through the machine a number of times to confirm the data. "The pressure exists if you only have a certain amount of resources," Dr Gibbs said, "and the temptation is not to test all of it so thoroughly because you have a lot of ground to cover."

"The big impact part of the project will occur over the next year, but that will be just the beginning."

After the working draft is completed, the consortium will go back to create the high-quality version, says Dr Gibbs. "The only danger is that we won't finish. The short-term gains from doing the draft might satisfy everybody enough so they won't be enthusiastic about pushing to get the quality that we think would benefit people the most."

The project has been a cross-disciplinary effort at Baylor, involving engineers, chemists, computer programmers, and others. "We've had to get about 100 people in here and work through doing this project properly. Such a cross-disciplinary project is unusual in biology," Dr Gibbs said.

The Human Genome Project plans to share its information with other public research centers as well as private ones. And Baylor is not the only Texas lab involved in the race to sequence the genome. The Genome Science and Technology Center at The University of Texas Southwestern Medical Center, headed by Glen Evans, MD, also has mapped millions of genes and was funded by NHGRI. Both labs' participation scores high marks for Texas as a mecca for medical research. "Texas should be proud," said Dr Gibbs. "I think the effects of this project will be explosive."

Many of the current genetic tests, including BRCA1 and BRCA2, though not 100% telling, can be much more informative if there is a known occurrence of cancer in the family history. The results can still provide valuable guidance to physicians. Dr Plon explained, "With BRCA1 and 2, for example, if someone is found to have a mutation, she really does have an increased risk for cancer. No, it is not an absolute determination, but the risk is still substantially increased. And that fact has been lost in all the noise about the fact that you can't give an absolute calculation." Navigating this gray area is something for which most physicians will need more education.

In their response to the POEP survey question asking when they would consider genetic screening, most physicians said they would consider it for breast and ovarian cancer and for Gardner's syndrome (familial polyposis of the large bowel). Dr Plon believes the respondents based their answers on tests they'd heard about rather than those that were most accurate and, therefore, most useful. "So, for example, the test for von Hippel-Lindau [VHL] disease had one of the lowest percentages in the survey, but that is actually a disease for which the DNA test is most indicated," she said.

"These disorders — VHL and multiple endocrine neoplasia, type II — are rare. Most physicians are not likely to see them in a given year," continued Dr Plon, "but for these disorders, clearly the best standard of care for a patient is to have the screening performed. Primary care physicians just aren't aware that these tests are available."

What's most relevant to your practice?

The key step in the process of genetic screening in general is determining which patients should have the tests performed. Aside from prenatal screening, the vast majority of tests are performed on pre-reproductive women and those patients with a high family occurrence of the disorder, according to Dr Beaudet. So, for most primary care physicians, it is important to understand how to take an appropriate family history.

Dr Plon says that genetic research is beginning to disprove common misperceptions among physicians. For example, in the case of breast cancer, Dr Plon says many physicians see the risk of inheriting the disease only through the mother's side, but a woman is equally likely to inherit the risk from the father's side. "Until these genes were cloned, it was hard to prove this one way or the other," Dr Plon said. "But now, it is actually well documented that a woman can inherit it from either side."

She also suggests physicians take note of the age of onset of the disease in relatives and in the patient. "I think many physicians are unaware of this, but the younger the patient is at onset of the disease, the more likely the disease can be linked to a genetic cause." She continues, "Also in the case of breast cancer, if it occurs in a member of the family who also has ovarian cancer, it is even more likely to be genetically inherited."

Dr Beaudet suggests that, in theory, the knowledge of a family's predisposition to certain disorders could lead to predictive screening and preventive measures that would save many lives. However, in actuality, Dr Beaudet said, "how effective the practice of contacting relatives turns out to be is not a simple matter."

"We should not let these concerns prevent us from vigorously exploring the benefits. Some inconveniences, emotional burdens, and financial costs can be accepted if the benefits are real and substantial."

The usefulness of genetic screening

Do these concerns outweigh the benefits of testing? In his presidential address to ASHG, Dr Beaudet said although the risks of genetic testing must be recognized, "We should not let these concerns prevent us from vigorously exploring the benefits. Some inconveniences, emotional burdens, and financial costs can be accepted if the benefits are real and substantial."

But speaking to *Texas Medicine,* Dr Beaudet said he believes there should be a speed bump to slow the increment of genetic testing referrals. "For many diseases, detection allows us to adjust risk and make predictions. In the case of Alzheimer's disease, for instance, we can say that one person's risk is higher than the next person's. But today, there's nothing we can do about curing the disease." He continued, "I think efforts to mount large screening programs just won't be successful unless they present a clear benefit to the people."

Dr Beaudet predicts that giving physicians a working knowledge of genetic testing will be a challenge as the science progresses, "but the education process is likely to parallel rather than precede implementation." He compared it with physicians' use of maternal-serum screening, which he said had "a generous mix of deficiencies and successes but eventual achievement of understanding comparable to that for any other aspect of complex modern medicine." ★

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Talking with teens

Getting adolescents to open up is vital to preventing risky behavior

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Teenagers. They're convinced they're immortal and that nothing bad will ever happen to them. And, of course, they know everything — or so they think. For physicians, eliciting information from adolescent patients about their lifestyles can be an exercise in frustration, especially with adolescents who practice behavior that compromises their health.

Given that the greatest threats to teenagers' health these days stem from their own behavior, experts say it is more important than ever to educate and intervene at every possible opportunity.

When physicians can get adolescents to open up, they truly can influence teens' decisions for the better. *Texas Medicine* asked several experts in adolescent health to share ways they've learned to handle touchy subjects with teens. ➤➤

By Teri Moran, Senior editor

Trust and confidentiality

First and foremost, in any encounter with teenagers, gaining their trust is essential, says Houston family practitioner Steven Cohan, MD. "They have to trust you. You need to come right out and say, 'I'm here to help you,' and assure them that what they say is confidential — that it's entirely between the two of you and no one else."

Dr Cohan recalled the 16-year-old girl who sat on his examining table and said, "Doctor, I missed my period; it was supposed to be a month ago. Please don't tell my mother."

Adolescents have the same right to medical privacy as adults. And unless they are suicidal or are being abused, what they tell their physicians is privileged, Dr Cohan says. "Of course, you encourage them to talk to their parents. If that teenage girl says her mother will 'kill her' if she found out, then I would say to her, 'You are your mother's child. Why do you think your mother will kill you? She may be disappointed in you, but your mother will help you.'"

At the People's Community Clinic in Austin where adolescent medicine specialist Celia Neavel, MD, practices, intake protocols imbue trust and confidentiality from the moment the adolescent walks in the clinic. Teen patients fill out their own confidential health histories, separate from the ones their parents fill out.

Dr Neavel addresses the adolescent primarily, asking, "Who brought you in today?" even if that person is standing nearby. "I've learned that it just works better to be upfront and take control of the encounter immediately," Dr Neavel said. "I tell both of them that it's my normal procedure to visit with the teen alone, then I ask the teen to step outside."

First, Dr Neavel spends a few moments alone with the parent, listening to concerns and asking questions. "Even on an acute visit I'll run through a brief list of risk behaviors, such as any changes in the teen's friends or a drop in grades," Dr Neavel said. Then, she meets with the teen alone and reiterates that the visit is confidential. "I do encourage teens to communicate with their parents, but they feel safer talking to their doctor alone." While the process may seem time-consuming, Dr Neavel says it is an efficient way to get information quickly.

Dr Cohan adds that it's important also to tell the parent that what the teen says will remain confidential. Confidentiality is extremely difficult to deal with in teens, Dr Cohan says, not because it's hard to keep what they say confidential but because it's hard to convince them that you will. "Kids don't want their parents to know they drink, smoke, use drugs, or are sexually active. That's why it's important to be very upfront about it and to tell the parents with the teen present."

> "They have to trust you. You need to come right out and say, 'I'm here to help you,' and assure them that what they say is confidential — that it's entirely between the two of you and no one else."

Temple pediatrician David Morehead, MD, adds that a physician should take precautions not to violate an adolescent's privacy unwittingly. "For example, what if an adolescent tests positive for a sexually transmitted disease [STD]? What happens when it comes to billing for that lab test? How do you protect the adolescent's privacy?" The physician may need to make special arrangements with the billing office, Dr Morehead says.

That kind of sensitivity fosters trust, Dr Morehead says. "Always be truthful, so they know that when you say something, you really mean it. For adolescents, that's really important."

Talking it through

The straightforward approach seems to be favored among experts who deal well with teens.

Bobbi Johnson, a licensed chemical dependency counselor and director of Austin's Phoenix House Council, says interviewing teens is like interviewing anyone else, and you should ask a lot of open-ended questions, such as: "Can you tell me a little bit about what's going on with you? What do you identify as your strengths? What are you really good at? Is there anything that needs

Sex, booze, and teens: counting the cost

In a series of policy statements that can be found on its Web site at www.aap.org, the American Academy of Pediatrics has gathered and summarized some of the latest research on the state of adolescent health in America.

- **The leading cause of death among Americans aged 15 to 24 years is alcohol-related motor vehicle injuries.**
- **Of all the adolescents who die in this country, 80% to 90% die from unintentional injuries, homicides, and suicides — in that order.**
- **Alcohol is implicated in the majority of deaths from unintentional injuries in adolescents.**
- **Although the teen pregnancy rate nationwide has fallen since 1991, it is still the highest among industrialized nations.**
- **As many as 1 million American teenagers get pregnant each year.**
- **In 1995, Texas had the nation's second highest teen birth rate.**
- **Half of all adolescents are sexually active by age 17.**
- **Of the 20 million cases of sexually transmitted diseases reported annually, one third occur in adolescents.**

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to improve in your life? Please tell me a little bit more about that."

Ms Johnson says you can almost determine teenagers' self-esteem levels by asking about their strengths and weaknesses, which helps you gauge how to talk to them. "If adolescents view you as a punitive person, they're less likely to open up," she added.

Dr Neavel often begins her interviews by asking teens about their general environment — home, school, and friends. "I'll ask if any of their friends smoke, or drink, or have gotten pregnant. Then I'll ask them how they feel about their lives and what plans they have for themselves."

Teens who have friends who engage in risky behaviors are more likely to do so themselves. Ms Johnson says she phrases some questions differently for teens who she knows are in a high-risk group. "Instead of asking them if they have ever used drugs, I'll say, 'When was the last time you smoked pot?' or, 'When was the last time you drank?' And then I ask them what other drugs they've used."

Dr Morehead says he prefaces interviews by telling teens that he needs to ask some touchy questions and that he asks them of all his patients. "I try to explain that I don't mean to be offensive but that I'm asking because it's important to their health."

Dr Neavel describes her conversations with teens as a tapestry, where she weaves in and out of topics, sometimes going back to one she wants to probe. "When I'm in the room with them, I try to pick up on what they're saying and reflect it back to them, and I'm always watching their body language. Can they maintain eye contact? I try to listen not only to what they're saying, but also to what they're not saying."

When Dr Neavel hits teens with the question about whether they're sexually active, she says they sometimes laugh. "But I just say, 'Hey, I ask that of everybody.'"

> "Often they won't tell you anything unless they have a good reason for telling you — and that's usually when they need your help."

Now that you know

If a teen says to you that she has had 20 sex partners, Dr Neavel says, "Don't freak out. Stay calm. Stay nonjudg-

TMA Advantage: Preventing teen pregnancy

There is no "magic bullet" that will provide instant success to the problem of teen pregnancy, according to the authors of Texas Medical Association's Position Paper on Teen Pregnancy Prevention. But physicians must be part of the solution, they say. No physician can do everything, but every physician can do something to address the issue.

TMA's Special Task Force on Teen Pregnancy Prevention has completed a study of teen pregnancy that also gives physicians guidance for dealing with individual patients and getting involved with community initiatives. For more information about the paper, call Kristine Niemeyer at (800) 880-1300, ext 1462, or (512) 370-1462; or e-mail kristine_n@texmed.org.

mental. Collect it as data. Say something like, 'Well, that concerns me,' and then share the dangers of having multiple sexual partners and unsafe sex."

If a 16-year-old girl wants a pregnancy test and doesn't want her mother to know, Dr Cohan says, you give it to her. "If it comes back negative, tell her about STDs — HIV, herpes, venereal warts, and chlamydia. Tell her how to protect herself. And if it comes back positive, explain each of her options."

You have to be prepared to do something when a teenager opens up, Dr Morehead says. "Often they won't tell you anything unless they have a good reason for telling you – and that's usually when they need your help."

Teen pregnancy is always a tough issue to deal with, Dr Morehead says. "I always ask whether their parents know and whether they plan to tell them; and I offer to help them tell their parents."

Dr Cohan always tries to encourage teens and their parents to make a safe drinking and driving pact, so that they can call their parents at any time or place and get a ride home "without getting yelled at."

At the end of the visit, always regroup and get some closure, Dr Neavel says. "Offer help and educate, and always make sure to schedule another visit. Don't just tell them you'll see them next time. Make sure they schedule another appointment, especially if you're concerned about something they're involved with and you want to spend more time with them."

"It's a doctor's job to cover all the bases," Dr Cohan said. "And if it takes more than 15 minutes, then, by golly, take it and use every resource at your disposal — nurses, social workers, therapists. It's a team effort." ★

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Who decides?

Debate over medical necessity becomes focus of patient protection fight

Artman

It seems like a simple concept. When patients are sick and need medical care, physicians decide what is medically necessary to restore their health. But in this day of cost containment and managed care, that's not how it works. Instead of the physician making that medical necessity decision, the health plan just might make the decision. And its definition of medical necessity may well be the cheapest treatment it can get by with, regardless of what the physician believes is best for the patient. ➤➤

By Ken Ortolon, Associate editor

That could change if the US Congress passes proposed legislation setting a standard for medical necessity. Such language appears in several patient protection bills now pending in Congress, including the Patients' Bill of Rights. Managed care companies and their business allies, however, are waging an all-out fight against the proposal and are determined to keep it from becoming law.

"Medical necessity has become the fulcrum of the patient protection debate in the Congress," said Kim Ross, Texas Medical Association's vice president for public policy. "The essence of what determines a physician's clinical autonomy and ability to determine what is appropriate care is his or her determination of what is medically necessary. We strongly believe that medical necessity determinations are the practice of medicine — not, as the health plans would have you believe, merely an insurance benefit determination."

Setting the standard

Nancy W. Dickey, MD, of College Station, president of the American Medical Association, says health plans have given themselves a free hand to deny care with the medical necessity provisions in their contracts. "The plans are using it as a mechanism to sidestep the appeals process and liability issue," Dr Dickey said. "The contracts say 'we will do those things that are medically necessary' and the next paragraph says 'and we, the insurance plan, will determine what's medically necessary.'"

According to a report by the AMA Council on Medical Service, an AMA review of managed care contracts found some medical necessity provisions that impose a "lowest cost" criteria. One contract defined medical necessity as the "shortest, least expensive, or least intense level of treatment."

Both TMA and AMA support proposals that define medically necessary care as that meeting "generally accepted standards of medical practice." That definition is contained in legislation proposed by Senate Minority Leader Tom Daschle (D-SD), Sen John Chafee (R-RI), Rep Greg Ganske (R-Iowa), and others.

Those bills, however, are staunchly opposed by the Health Benefits Coalition, a group made up of managed care plans, large employers, and other business and insurance industry groups. Chip Kahn, president of the Health Insurance Association of America (HIAA), called the medical necessity legislation a "trial attorney's dream," saying it would throw what has been a contracting issue into the hands of the courts and government bureaucrats. HIAA is a member of the Health Benefits Coalition.

"The whole coalition feels very strongly that this legislation would unnecessarily increase health care costs and price small employers particularly out of the market," Mr Kahn said. "Our opposition is grounded in the strong belief that the first priority ought to be keeping Americans insured and trying to reduce the number of uninsured."

In heated congressional briefings, the managed care plans have called the proposals "institutional mediocrity" that will "raise health care costs, reduce quality, and lead to increases in health care fraud."

And that's the low-key response. Handouts from the health plans to members of Congress scream, in boldface type, "This provision would be the end of insurance as we know it ... a sure fire way to government-run health care ... directly threatening the quality of care ... a type of extreme fee-for-service system."

Coverage versus care

Mr Kahn says the idea of the insurer making the decision on what is medically necessary is not new. The administrators of both the Medicare and Medicaid programs determine medical necessity, he points out. No one is talking about changing that for those programs, he adds.

Mr Kahn says giving the medical necessity decision back to physicians would allow them to determine what's covered by the health plan. And, it would free them from what he called the "sentinel effect" of having the plans review their treatment decisions. That, he says, would allow "certain unbridled providers" to order more tests, perform more procedures, or provide services that are not necessary.

"We're talking about the coverage decisions, not the care decisions," Mr Kahn said. "In terms of making the coverage decision, that has to be held with the people who have the fiduciary responsibility to the person covered and the premium payers. The physician or other provider ordering a test has no fiduciary responsibility to the premium payer."

> "The essence of what determines a physician's clinical autonomy and ability to determine what is appropriate care is his or her determination of what is medically necessary."

Supporters of the medical necessity language, however, say Mr Kahn is incorrect when he argues that the legislation turns coverage decisions over to the physicians.

Nothing in the Patients' Bill of Rights or the other proposals requires a plan to pay for care simply because the physician feels it is medically necessary. Any service requested still would have to be a covered benefit. And, nothing would prevent health insurance plans from continuing to work with physicians to educate them in best practices and provide them with evidence-based criteria for medical treatment decision-making. Medical necessity determinations would be required to consider evidence-based criteria when available, peer-reviewed criteria when available, or generally accepted standards of care. A physician who demonstrates a pattern of refusing to make medical decisions based upon these guidelines could be removed from the plan's panel.

All articles in *Texas Medicine* that mention Texas Medical Association's stance on state legislation are defined as "legislative advertising," according to Texas Govt Code Ann §305.027. That law requires disclosure of the name and address of the person who contracts with the printer to publish the legislative advertising in *Texas Medicine*: Louis J. Goodman, PhD, Executive Vice President, TMA, 401 W 15th St, Austin, TX 78701.

Dr Dickey says the AMA agrees that health plans have every right to decide what is and isn't covered — they just ought to tell insureds what isn't covered up-front.

"The problem is that they don't want to tell patients what's not covered because it makes it harder to sell the product," she said. "Rather than telling a patient that a service is not covered, they say it's not medically necessary. Well, there's a difference between those two. Medical necessity is based upon diagnosis and acceptable practice interventions usually based on scientific, peer-reviewed studies or consensus statements.

"If they say to insureds that they cover everything that's medically necessary," Dr Dickey continued, "and then they determine medical necessity based on monetary considerations, they've chosen to take care of their shareholders rather than take care of the patients they've contracted to care for."

Sizing up the odds

The debate over whether medical necessity is a coverage issue or a medical decision will continue. Meanwhile, patient protection legislation is beginning to move forward. On March 18, the Senate Health, Education, Labor and Pensions Committee passed the Republican leadership version of the Patients' Bill of Rights. Unfortunately, that bill and similar legislation backed by the House GOP leadership do not contain the medical necessity definition. Efforts by Democratic members of the committee to add that language were voted down on a straight party-line vote.

According to an AMA analysis, the Republican bills would place the burden of proof of medical necessity on the physician, not the health plan. In fact, the Republican bills would give health plans total authority to deny treatment without any required standard. Dr Dickey says that is unacceptable.

"We [physicians] have to use up-to-date science, and the insurance plans should hold doctors to a standard of science," she said. "But doctors should be able to do the same to the health plans."

Despite the fact that the Republican leadership has sided with the health plans, Dr Dickey says chances are still "fairly good" that a bill AMA can support will be produced. The measure must go through two more Senate committees and three House committees. AMA lobbyists say each of those stops will provide a venue to add another piece of the patient protection puzzle, whether it be the medical necessity definition, an acceptable external appeals process, or the right for patients to sue health plans for negligent decisions.

And, there likely is more bipartisan support for those provisions in the House, where Republicans such as Congressman Ganske, Rep Tom Coburn (R-Okla), Rep Charles Norwood (R-Ga), and others have shown support. Representatives Ganske and Coburn are physicians. Representative Norwood is a dentist.

Congressman Ganske, in a passionate letter to his colleagues in the House, said "Some health plans are manipulating the definition of medical necessity to deny appropriate patient care by arbitrarily linking it to saving money, not the patient's medical needs.

"As a former medical reviewer myself, who worked with many insurers large and small," he also noted, "let me explain why I think it is critical that we stick with medical necessity as defined by clinical standards of care. First, sole reliance on broad-based standards from generalized evidence isn't good medical practice; second, there are practical limits to designing studies that can answer all clinical questions; and third, most studies aren't of sufficient scientific quality to justify overruling clinical judgment."

The larger question may be whether this Congress has the will to pass a measure that has been such a political hot potato. Some observers say the Republicans don't want to be perceived again as blocking patient protections with an important election year coming up. Democrats gave them a beating on the issue last year, and the GOP ended up losing several seats in the House, cutting into its majority.

Mr Kahn, however, says he doesn't see any real zeal on the part of Democrats to push a bill through because they'd rather keep the issue hanging on so they can use it again as campaign fodder.

Dr Dickey agrees that politics is getting in the way of much-needed legislation. "I fear that politics on both sides of the aisle are keeping our elected leadership from demonstrating responsibility in an area that is a serious problem for their constituents and our patients," she said. "And I think it is time that we call upon those people to be statesmen and problem-solvers and not politicians."

"I fear that politics on both sides of the aisle are keeping our elected leadership from demonstrating responsibility in an area that is a serious problem for their constituents and our patients."

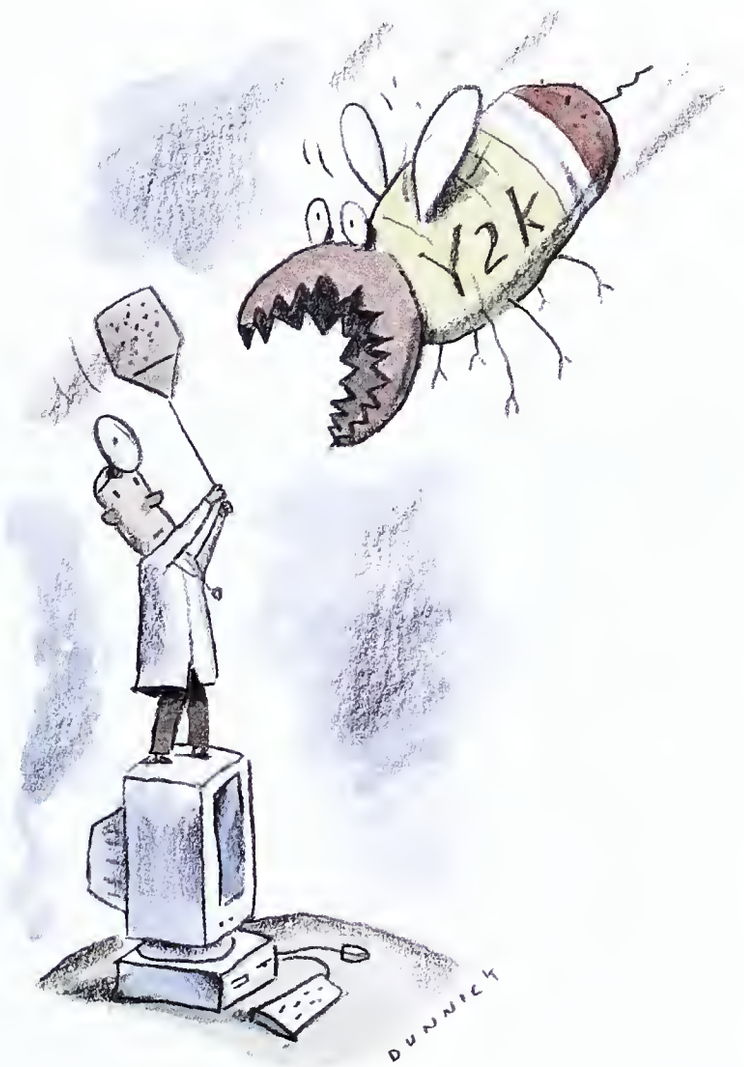
She says that may take some strong grassroots action by physicians. "Doctors have got to recognize that if these issues are as important with their patients as TMA and AMA believe they are, it is up to us to mobilize our patients," Dr Dickey said. "We need to be sure our patients and our communities understand that they should not wait for the next election cycle to tell their congressmen and senators how important this is. They ought to be telling them right now by letters, postcards, phone calls, and town meetings that this issue cannot be ignored and that their willingness to provide leadership is something they will be held accountable for." ★

Preparing for 2000

Cover your bases with this Y2K checklist

We all have to face the fact that the year 2000 (Y2K) is just around the corner. As a whole, the health care industry has inched its way to the bottom of the Y2K compliance list as compared with other industries.

Texas Medical Association Physician Services (formerly Texas Physician Services Organization) offers a checklist to help you evaluate which parts of your practice Y2K will affect and what preventive steps you need to take. ➤➤



Regan Dunnick

By Teri Moran, Senior editor

If you have software applications on your computer that take automatic action based on the date of your personal computer (PC), make sure these applications are disabled before conducting *any* tests. Otherwise, you may damage or lose your data. Also, it is always a good idea to back up the data before *any* test.

If you haven't already done so, begin testing your computers now because it could take anywhere from 2 weeks to 3 months or more to get new computers and new software installed. Develop a plan with specific deadlines for taking whatever corrective action is necessary based on the following checklist. When looking at new software and consulting services, don't hesitate to shop around for the best price.

If you haven't already done so, begin testing your computers now because it could take anywhere from 2 weeks to 3 months or more to get new computers and new software installed.

Step one: Develop a Y2K plan

- Develop awareness personally and among your office staff. Assign one person to head a team that will oversee your Y2K project.
- Assemble a project team of trusted individuals who will be responsible for developing a Y2K plan and making sure it is implemented properly.
- Establish a budget to pay for future Y2K upgrades.
- Assess and document the risks of not becoming compliant. Evaluate those areas of your practice that are most vulnerable. Prioritize when they will be addressed.
- Consult your attorney to determine your potential Y2K liabilities and contact your insurance agent to ensure that you are covered in case you suffer any operating losses.

Step two: Inventory your office

Take a complete inventory of all computers and other items that contain a computer chip with date-coded logic. This involves making a list of just about everything that is plugged into an outlet, including printers, fax machines, scanners, and modems. The purpose is to find out how compliant the equipment is for the year 2000 by testing the equipment yourself, by asking the manufacturers, or by gathering the information from another reliable source.

Step three: Test your office equipment

The American Medical Association's Web site at www.ama-assn.org con-

Dates to test for Y2K problems

September 9, 1999: **This date may be stored as 9/9/99, which some systems see as a special processing event flag.**

December 31, 1999: **The last date using "99" in a two-byte field. For systems that "look forward" as part of the date processing, this may cause errors when the date is used with the "00" of the year 2000.**

January 1, 2000: **The first date using the "00" in a two-byte field. For systems that "look back" as part of the date processing, this may cause errors when used with the "99" of 1999. The "00" also may be considered an event flag to trigger some special type of processing within a system.**

January 2, 2000: **The first date where the 24-hour look-back processing in a system may cause an error because of manipulation of "00" in computing the look-backward event.**

January 10, 2000: **The first date that must display seven digits rather than six for the century to be definitively understood as 2000 rather than 1900.**

February 28, 2000: **To ensure the system will correctly roll over to February 29, 2000.**

February 29, 2000: **To ensure the system will correctly roll over to this date, as well as attach the appropriate day of the week.**

March 1, 2000: **To see that the system will correctly roll over to this date after having successfully rolled over to February 29, as well as the correct day of the week and day of the year.**

October 10, 2000: **The first date that must display eight digits rather than six or seven for the century to be understood definitively as 2000 rather than 1900.**

December 31, 2000: **The last date using "00" in a two-byte year field. For systems that look forward as part of date processing, this date may cause errors when the date is used with the "01" of 2001.**

tains detailed instructions for checking your PC for Y2K problems. Before performing any tests, be sure to back up your system and files. The following test steps will help you determine your PC's Y2K readiness:

- Set the date on your PC to December 31,1999, and the time to 23:55 hrs (11:55 pm). (Look up instructions on your operating system's "Help" function if you do not know how to set your PC's date and time.)
- Shut down the computer in the normal manner and turn the power off.
- Wait at least 5 minutes and then turn on the PC.
- Verify that the date is Saturday, January 1, 2000, and the time is a few minutes past midnight.
- If the day of the week, date, or time is incorrect, you have a problem with your system's BIOS (basic input/output system), which manages the system's clock. You may need a BIOS software upgrade or a BIOS chip replacement. Contact the computer's manufacturer for an upgrade. BIOS is the program a PC's microprocessor uses to start the computer system after you turn it on. It also manages data flow between the computer's operating system and attached devices such as the hard disk, video card, keyboard, mouse, and printer.
- Repeat the test by changing the date and time on the computer without shutting it down or turning off its power. See "Dates to Test for Y2K Problems" for other relevant dates you should test.

Step four: Determine if suppliers and vendors are Y2K compliant

Any equipment that contains an embedded chip is at risk. Contact external vendors for a written guarantee that their products are Y2K compliant and that deliveries to you will continue. If equipment cannot be upgraded, determine how it can be replaced. Organizations to contact include systems manufacturers, suppliers, vendors, and business partners.

If equipment cannot be upgraded, determine how it can be replaced. Organizations to contact include systems manufacturers, suppliers, vendors, and business partners.

Contact all organizations with which you exchange information or data to find out their Y2K status, including the federal government, private insurers, hospitals and clinics, testing laboratories, banks, and credit card companies. You might consider talking with other hospitals in the area about getting temporary admitting privileges in case the hospital to which you regularly admit ends up having major Y2K problems when January 1, 2000, arrives.

Assess the readiness of telecommunication equipment such as your phone system, mobile phones, pager systems, and answering services. Contact manufacturers and ask about the Y2K status of each piece of equipment.

If you own your own building, you should have its Y2K status checked for all monitoring and control systems, such as air conditioning, water, and electricity. Also check safety equipment such as fire alarms, energy management lighting controls, and emergency lighting control systems. If you do not own the building, contact the property owner to verify that all of the previously mentioned systems are Y2K compliant.

The practice management software you use in your office is also at risk for Y2K problems. Ask your vendor these

Y2K readiness Web sites

www.texmed.org
Click "Business of Medicine" at Texas Medical Association's Web site.

www.ama-assn.org/not-mo/y2k
The American Medical Association's Web site. Also see more Y2K guidelines in the "Members Only" section.

www.rx2000.org
Healthcare's Year 2000 Information Clearinghouse.

www.y2kinfo.com or www.y2khealth.htm
Datamation's Web site includes examples of Y2K liabilities in the health care industry.

www.itaa.org or yr2000bg.htm
Information Technology Association of America Year 2000 Task Group's Web site houses a buyer's guide for Y2K conversions software.

www.fda.gov
The Food and Drug Administration's Web site has resources to help you determine if your equipment is Y2K compliant. For equipment not listed, contact the manufacturer directly.

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questions when taking inventory of your practice management software:

- Is my software version Y2K compliant?
- What is the earliest date a noncompliant version would fail?
- When will the compliant version be available for testing?
- How long will it take to install the new version?
- Are data-conversion programs supplied with the new version?
- Will you issue a Y2K compliance warranty?

Check medical equipment, such as biomedical equipment, intravenous pumps, heart defibrillators, pacemakers, CT scans, dialysis machines, physiomonitoring machines, and diagnostic equipment. Consult the Food and Drug Administration's Web site at www.fda.gov to find out if your equipment is compliant. If your devices are not listed, contact the manufacturer directly.

Step five: Develop a contingency plan

Prepare a contingency plan for handling your business if systems are not operable. To minimize potential inconvenience should any of your systems fail, take the following steps before January 1, 2000:

- Mail year-end statements.
- Pull together W-2 and other payroll information.
- Arrange to have a line of credit available in 2000 to cover expenses if insurers are late with reimbursements or to correct unforeseen Y2K-related problems.
- Print a hard copy of year-end trial balances.
- Call your insurance agent to make sure you're covered in case of operating losses, which could be excluded as business liability risks.

Finally, to minimize potential liability, you should predict and prevent problems that might occur. Record all your attempts to minimize problems relevant to the rollover. Confirm that contracting parties have satisfactory insurance coverage for Y2K problems. Ensure there is adequate indemnification under any contract, and verify that insurance for the business includes coverage for losses related to Y2K. ★

Write your carriers and build cash reserves while you can

"Slow-pay, no-pay" from health maintenance organizations and other payers has long been a problem for physicians. Imagine then, what may happen when the year 2000 rolls around.

"I'm sorry, doctor, but we're having problems with our system and we don't know when they will be resolved," is a message physicians very likely may hear frequently.

Even the smallest piece that fails in the claims processing and approval process could cause payers not to be able to pay, says Teresa Devine, Texas Medical Association's director of health care financing. "We don't have any reason to believe that physicians should rely on their carriers to have all the bugs worked out. Therefore, they should build cash reserves now and build them aggressively."

Physicians should write letters to all carriers with which they contract and ask them to confirm in writing whether their claims processing and payment systems are Y2K compliant. "If you do not receive a yes, you may as well assume the carrier is not compliant and you should expect payment delays," Ms Devine said.

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Third-party funding of health care services for the uninsured of Tarrant County

RICHARD A YOUNG, MD

This study investigated how many citizens of Tarrant County do not have health insurance, what sources fund their health care, and how this level of funding compares with the privately insured population. Data for 1995 were obtained from various government agencies, local hospitals, local charitable organizations, and a survey of local private physicians. Medicare and Medicaid were considered to be forms of health insurance. Approximately 20% of the citizens of Tarrant County did not have health insurance. Third-party funding for health care for this population was approximately 56% of the funding for the privately insured population ($967 vs $1726 per person per year). The Tarrant County Hospital District contributed 52% of the uninsured funding; private hospitals and physicians, 26%; other state and local agencies, 21%; and charitable donations, 1%. I conclude that health care for the uninsured of Tarrant County is rationed compared with that of the privately insured population.

Dr Young, clinical associate professor, Department of Family and Community Medicine, John Peter Smith Hospital, an affiliate of The University of Texas Southwestern Medical Center at Dallas, 1500 S Main, Fort Worth, TX 76104.

Preliminary data were presented in January 1998 at a conference on the uninsured of Tarrant County, sponsored by the Tarrant County Community Ethics Consortium, and in April 1999 at a meeting of the Western Social Science Association, Fort Worth.

INTRODUCTION

Many studies have shown that uninsured patients experience barriers to obtaining timely and appropriate health care services. These patients also have worse outcomes (1–9).

Children without health insurance are less likely to visit a physician for conditions with potentially serious sequelae, receive fewer inpatient services, and are less likely to have a usual source of care (1–3). Uninsured adults are less likely to see a physician for acute or chronic illnesses, are more likely to have a ruptured appendix, are less likely to receive preventive services, are less likely to receive high-cost procedures in the hospital, and make fewer physician visits per year (4–9).

The health care needs of the uninsured are essentially the same as those for the insured. The uninsured are slightly younger than the insured and more likely to be members of a minority group (10,11). However, a higher percentage of the uninsured report their health status as being fair or poor (9,10,12). A recent controlled trial of previously uninsured patients enrolled in a commercial health maintenance organization (HMO) found their utilization after enrollment to be slightly greater than that of previously insured patients (13).

The purpose of this study was to investigate how many citizens of Tarrant County do not have health care insurance, where they go for health care, who pays for it, how much is paid for it, and how that level of funding compares with that of the privately insured population. Data on the health outcomes of the uninsured population compared with those of the privately insured population were sought also.

METHODS

General

This study focused only on traditional health care services. Administrative costs of delivering health care were included in the estimates. Services not related to health care (eg, food banks, homeless shelters, and clothing drives) were not included. All estimates were for 1995.

Estimates of the number of uninsured in Tarrant County were obtained from various sources. The Texas Department of Health (TDH) estimate for Tarrant County was a mid-range estimate generated specifically for this study and, therefore, was used for baseline calculations (K Condon, TDH, written communication, January 1997 and August 1998).

Private hospitals

Data on uncollected charges for uninsured patients were obtained from TDH for all Tarrant County hospitals. Charges were converted to costs in the following way. Data on charges and costs of uninsured care were obtainable for 5 hospitals. The charge/cost multiplier for these hospitals was averaged and applied to those hospitals that only reported charges to estimate their actual costs.

One difficulty in capturing only those costs associated with uninsured patients is that the hospitals do not report their uncollected charges by insurance status. Only 1 hospital was identified that could estimate the percentage of "charity care" and "bad debt" charges by insurance status (90% and 57% uninsured, respectively). These ratios were applied to the other private hospitals.

Private physicians

A systematic telephone survey of 50 private physicians' offices was performed also. This number of offices was calculated a priori to predict the percentage of private offices that saw uninsured patients ±10% (= 2 SE). The Tarrant

County Medical Society membership directory was used. The first office called was chosen by a random number generation process, then every 36th office was called to collect the 50 data points.

The office manager of each office was interviewed. The purpose of the survey was explained, and assurances were given that the anonymity of individual responses would be maintained. Essentially, 2 questions were asked: "How many of Dr Smith's patients have no health care insurance?" and "Of the charges generated in taking care of these patients, how much of it is collected?"

All of the uncollected charges were counted as the private physicians' donated charity care. In other words, if a physician's practice saw uninsured patients but collected the entire bill up front before the patient was seen, this was not considered charity care.

Total practice revenue estimates by specialty were obtained from a national survey (14). The value of charity care was calculated by the following formula: charity care = percentage of physician's patients who are uninsured X (1 – proportion of bill collected) X the average practice revenue for that specialty. The total private physician contribution was estimated by multiplying the average uninsured patient charges by the total number of active physicians in Tarrant County, as measured by TDH.

In general, responses were tabulated to maximize the amount of charity care credited to these practices. For example, many respondents, when asked, "What percentage of your patients do not have health care insurance?" would give an answer such as "Less than 5%." If further questioning failed to determine a specific number, 5% was used for the calculations.

Charitable organizations

Local charitable organizations that provide health care services to uninsured patients were surveyed as well. Agencies were identified by consulting the United Way and talking to knowledgeable social workers. Each agency was telephoned and asked to provide information on the total value of health care services provided to uninsured patients. Services could include free testing, counseling, durable goods, and home health services. Administrative costs for these services were included also. Not included were general information and outreach services such as staffing "hotlines" and cardiopulmonary resuscitation training. Donations made to hospitals to help cover unreimbursed care were not separated from the hospitals' uninsured care costs.

Government entities

The Tarrant County Hospital District estimate was obtained from the district administration. The funding for uninsured patient care dollars was estimated to err on the side of overestimating the available dollars. Revenues from Medicare, Medicaid, and private insurance were subtracted from the total revenues to yield the total revenues available for uninsured health care.

The district has expenses not related to patient care, such as a licensed vocational nursing school, that were not subtracted from this total. No attempt was made to estimate and subtract dollars devoted to subsidizing either poor patients on Medicare (eg, the district subsidizes their medications) or patients who are underinsured by Medicaid. Additional state and federal revenues for house staff training also were not subtracted.

Information on the cost of health care services provided by the Department of Mental Health and Mental Retardation (MHMR) was obtained directly from that agency. Costs included all services not funded by third parties (ie, Medicaid patients). Services included inpatient and outpatient psychiatric services, alcohol and drug rehabilitation treatment centers and counseling services, mental retardation services, and other related counseling services. Administrative costs were included also.

Information on the cost of health care services provided by the Fort Worth/Tarrant County Health Department was obtained from that agency. Costs included all direct health care costs such as the clinics for patients with sexually transmitted diseases, acquired immunodeficiency syndrome, and tuberculosis. Activities such as restaurant inspections, animal control, and other general public health activities were not included.

The University of North Texas Health Science Center provides some uninsured care through its medical student clinics. Patients are charged on a sliding scale fee structure. The cost of providing this care was identified.

Private insurance comparison

Estimates for the annual expenditures by private insurance companies for insured patients were made by 2 methods. These estimates were for patients younger than 65 years, because almost all Americans 65 years or older qualify for Medicare.

Data on national health care expenditures by third-party payers for populations of patients younger than 65 years were obtained from the medical literature (15). Costs for public health activities and research were excluded. All other third-party costs were included. Out-of-pocket costs were excluded.

Data on health care expenditures for a local HMO population were obtained to validate the national data. Information was obtained from the Texas Department of Insurance on the expenditures and enrolled patients of the 4 largest HMOs in Tarrant County. The expenditures for patients aged 65 years and older in these HMO populations were excluded.

The estimates for both methods were averaged (weighted by the local market HMO penetration) to establish the insured population comparison case.

RESULTS

Number of uninsured

Approximately 20.1% (13.2% to 27.0%) of the people in Tarrant County did not have health insurance in 1995. Other estimates fall within this 95% confidence interval (CI) range (Table 1). Tarrant County had a population of approximately 1.3 million people in 1995, which means approximately 261,000 people had no health insurance.

Governmental entities

The Tarrant County Hospital District provided approximately $130.1 million in health care to the uninsured. This equals 52% of the total amount of uninsured funding.

The amount of care provided by MHMR was $39.6 million; the Fort Worth/Tarrant County Public Health Department, $13.0 million; the University of North Texas Health Science Center at Fort Worth, $150,000. These agencies combined contributed 21% of the total uninsured funding.

Private physicians and hospitals

Forty-two practices (84%) responded to the survey. The results are shown in Table 2. The reported ranges represent the 95% CI of the mean.

Results for the private hospitals are shown in Table 3. They reported approximately $51.2 million in health care costs for uninsured patients. Private physicians and hospitals contributed 26% of the total uninsured funding.

Charitable agencies

The total amount of care donated to uninsured patients through charitable organizations was $3.2 million. Most of these funds were concentrated in 5 agencies (a counseling center, a child development/learning evaluation center, a Christian medical durable goods supply company, a hospice program, and a cancer care service). Charitable agencies contributed 1% of the total uninsured funding.

Table 1. Estimates of uninsured population, in percent.

Source and Year	Tarrant County	PH Region 3*	Texas
John Sharp, 1989-1992 †	14.4		
United Way, 1992 ‡	11.4 (of adults) 18.8 (of children)		
Texas Department of Health, 1993		20.3	23
Texas Medical Association/ Texas Department of Health, 1994	20.1		17.1
US Census, 1995			24.5

* Public Health Region 3 encompasses the North Central Texas area, including Tarrant, Dallas, and surrounding counties.

† John Sharp, Texas Comptroller of Public Accounts (number is for Fort Worth only).

‡ Based on phone survey with no correction for households with no phones.

Private insurance funding

The estimate based on national personal health care statistics for the annual cost of health care in a population younger than 65 years and not receiving Medicaid was $1751 per person per year. The estimate based on information reported by the 4 largest local HMOs was $1650 per person per year.

The weighted average of these 2 estimates (assuming 25% HMO market penetration) was $1726 per person per year. This figure was compared with the uninsured figures.

Uninsured versus insured funding

Third-party health care expenditures for the uninsured citizens of Tarrant County totaled $252.3 million. This results in $967 per uninsured person per year, which is 56% ($967/$1726) of the funding available for insured citizens.

Even if the lowest value of the TDH estimated range of percentage of uninsured in Tarrant County (13.2%) is used, uninsured funding is still lower than insured funding ($1470/$1726 = 85%).

Comparison with other Texas counties

A comparison of uninsured funding for public and private hospitals for Bexar, Dallas, El Paso, Harris, and Tarrant Counties is shown in Table 4. Tarrant County uninsured expenditures fall in the middle of the expenditures of these other 4 counties.

CONCLUSION

This study documents the disparity of funding for health care for the uninsured of Tarrant County as compared with funding for the insured.

This study only examined third-party funding of health care. The uninsured are much poorer than the insured. Approximately 60% to 62% of the uninsured have incomes below 200% of the federal poverty level compared with 24% to 35% of the insured (10,11). Therefore, the uninsured are less able to balance the decreased third-party funding with out-of-pocket payments. This disparity strongly suggests that health care for the uninsured of Tarrant County is rationed.

Findings from this study are consistent with observations from other investigators. A national study found that the uninsured had approximately 60% of the

Table 2. Percentages and costs of private practices treating uninsured patients in Tarrant County, 1995.

	Percent	Cost
Physicians who see any uninsured patients	95 (88–99)	
Physicians' patients who are uninsured	6.7 (4.6–9.5)	
Uninsured patients charges that are collected	61 (49–72)	
Average amount of uncollected charity charges per physician		$7,330 ($3,800–$11,200)
Total value of private physicians' charity care $7330 x 1938 active physicians =		$14.2 million ($7.4–$21.7 million)

Table 3. Private hospital costs for treating uninsured patients in Tarrant County, 1995.

Hospital	Millions of Dollars
Hospital A	13.2
Hospital B	5.0
Hospital C	4.4
Hospital D	3.8
Hospital E	3.5
Hospital F	3.0
Hospital G	2.9
Hospital H	2.9
Hospital I	2.6
Hospital J	1.7
Other hospitals	8.2
Total	51.2

funding the insured had, which is similar to this study's finding of 56% (16).

Tarrant County uninsured expenditures fall in the middle of the other 4 counties examined. In general, the counties with larger populations had higher expenditures per uninsured person than did the smaller counties. Migration of noncounty resident patients to tertiary care centers could account for some of this difference but could not be measured directly. For example, if the bad debt and charity charges of M.D. Anderson are taken out of the Harris County figures, the private hospital uninsured charges per person drop from $493 to $363, and the uninsured costs drop from $296 to $219.

Ninety five percent of Tarrant County physicians reported that they cared for at least some uninsured patients, which is higher than other surveys reporting 67% to 77% (17,18). The Tarrant County physicians reported that 6.7% of their patients are uninsured, which is higher than a Wisconsin survey reporting 4.6% (19). Wisconsin has a smaller percentage of uninsured, which explains some of this difference (20).

Another possible explanation for the overall funding difference is that the US private insurance system is still plagued by significant inefficiency. The United States spent 14.2% of its gross domestic product (GDP), or $3708 per capita, for health care in 1996 (21). The next highest expenditures in other developed countries included Germany (10.5% GDP, $2222 per capita), Switzerland (9.8%, $2412), and Canada (9.2%, $2002). In return for this excess expenditure, the United States ranked 21st in infant mortality and 20th in life expectancy.

An important distinction to be made between these international figures and those reported in this study are that the international figures include all health care related expenditures, including out-of-pocket expenses, nursing homes, medical education, and research. This study examines only third-party payments for personal health services.

This study included information obtained from various sources. All of the major providers of health care in Tarrant County were included. Other contributors of health care services to uninsured citizens may have been excluded. Occasional services such as health fairs with free health screenings were not included. Even if agencies or services not accounted for in this study were considered in future research, the fundamental conclusions most likely would not be altered.

Another weakness of this study is the voluntary reporting of data on uncollected charges. Almost all estimates were provided by the hospitals and other entities themselves, with no independent accounting by TDH. This gives a potential bias of overestimating the actual costs incurred.

A small discrepancy existed between the 2 insured population funding estimates. However, this discrepancy has some reassuring internal validity. The national data included all forms of third-party payment. Annual HMO expenditures per capita are well known to be lower than those of traditional indemnity insurance (22), which is consistent with the findings of this study.

Presumably, the rationing of health care in Tarrant County leads to worse health outcomes for the uninsured population, such as worsened overall mortality, increased cardiovascular morbidity

Table 4. Comparison of uninsured finances by county, 1995.

	Bexar	Dallas	El Paso	Harris	Tarrant
Percent of population uninsured (SE)*	22.9 (1.8)	19.4 (1.5)	34.4 (3.8)	23.8 (1.3)	20.8 (1.8)
Total number uninsured (in thousands)	298	388	230	738	270
Private hospital uninsured costs per uninsured person ($/yr)†	136	259	62	296	189
Private hospital uninsured bad debt and charity charges per uninsured person ($/yr)‡	226	431	103	493	315
Public hospital ad valorem tax revenue per uninsured person ($/yr)	275	387	135	279	381
Public hospital ad valorem tax revenue plus disproportionate share revenue per uninsured person ($/yr)	354	503	224	356	421

* Average for 1994–1996 as collected by the Texas Behavioral Risk Factor Surveillance System, Ken Condon, Texas Department of Health.
† Charges adjusted by hospital charge/cost ratio and percentage of bad debt and charity care patients that are uninsured.
‡ Private hospitals defined as all hospital facilities not receiving ad valorem hospital district tax revenue.

and mortality, and increased cancer morbidity and mortality. However, health outcomes for the uninsured of Tarrant County are unknown because no agency compiles the data.

Approximately $200 million would be required to make the third-party funding of the uninsured equal that of the insured of Tarrant County. This would require a property tax increase of approximately 200%. Alternatively, this would require private hospitals and physicians to increase their care by approximately 300%. Neither increase is likely to happen. Therefore, creative approaches are needed to provide the best possible health outcomes for the uninsured, given the rationed dollars society provides for their care.

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The public health care of Central Americans in Houston

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In recent years, Americans have witnessed a marked change in the source of immigrant groups. Current immigrants are more likely to be former residents of the less developed world (nations such as Guatemala, Nigeria, India, and Viet Nam) than were earlier immigrants. In urban Texas, the influx of peoples from Central America is particularly striking and is largely a consequence of homeland political and economic instability. The new immigrants tend to be young and sexually active. We analyzed utilization patterns of Central Americans at our district health care facilities over 18 months and compared results with those of our non-Central American health care recipients. The 30,000 annual visits by Central Americans accounted for 4% of all visits. Disproportionately large amounts of care were given for sexually transmitted diseases and obstetric problems; conversely, small amounts were given for chronic illnesses, infectious diseases, acquired immunodeficiency syndrome, mental health problems, and adverse fetal outcomes. Few exotic tropical diseases were recognized or treated.

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INTRODUCTION

Immigration patterns to the United States are changing. The stereotype of our 19th century immigrant was a European living in the tenements of New York. Today, the stereotype might be a former resident of the Pacific Rim who inhabits a suburban Sunbelt apartment complex. While our grandfathers contended with the intraethnic conflicts of Irish, Italian, Czechoslovakian, Mexican, and African American immigrants, today's populace is more apt to address the problems of an immigrant with the cultural heritage of India, Pakistan, Nicaragua, or Bosnia. The predominantly European populations of the past, who often shared a religious and cultural orientation, have been replaced with a patchwork of groups with far greater philosophical and ethnic diversity.

Immigration to Texas is changing similarly. For many generations, Texans have witnessed significant immigration across the Rio Grande border (Rio Bravo del Norte), perhaps the longest interface between less and more developed nations in the world. Today, with the ease of air transport and the advent of peoples from all corners of the globe, a Houstonian's pharmacist is often a native of Nigeria or West Africa; his cleaning assistant, a former resident of Central America; and his mechanic, a first-generation Vietnamese. To know their health status requires an understanding of the health problems and diseases endemic to these areas.

To assess the health care of such immigrant populations, we analyzed the health care indices of one group: Central American immigrants to Houston who use Harris County Hospital District (HCHD) services. The presence of a large Hispanic infrastructure in Houston facilitates immigration from less developed nations of Latin America, especially those of Central America, and explains the choice of destination.

Central American immigration is a product of both economic and political native turmoil. The estimated 100,000 Central Americans in Houston make up 20% of the local Hispanic population (1,2). Among the local Central American population, the oldest, most established group is the estimated 50,000 to 80,000 Salvadorans who immigrated between the early 1970s and the 1990s as a consequence of the civil war in El Salvador. A smaller Guatemalan community arrived more recently and includes 2 distinct indigenous groups from Totonicapán and El Quiche. A Honduran population in Houston of 5000 to 10,000 arrived in the mid-1980s, often for economic reasons, because the median income of Honduras exceeds only that of Haiti in North or Central America. Because public facilities provide the largest share of indigent health care, an analysis of public databases is a starting point toward understanding the health care problems in immigrant populations.

Public health issues of Central American immigrants receive scant attention. Their arrival is relatively recent, their numbers are erroneously thought to be small, and the immigrants themselves are reluctant, especially when undocumented, to share information. The tendency to consider Hispanic immigrants homogeneously and apply Mexican American data to Central American and other Hispanic groups is misleading. Hence, with a need for specific studies of Central American immigrants, we review current knowledge about Central Americans' health status and analyze data on their health care utilization in Houston.

BACKGROUND

Central America

The 31 million Central Americans range from the ethnically homogenous, densely populated residents of El Salvador to the diverse, Mayan descen-

dants of Guatemala and the African, Creole, and Caribbean-descended Garifuna heritages of Belize. The health care systems of the 7 Central American nations differ radically, the most sophisticated being that of Costa Rica whose investment in health was a product of cooperation with the United Fruit Company and a consequence of a developed economy and stable political structure. Other Central American health care systems are less successful. While nations such as Belize declared health care a human right, significant disparities between rural and urban health care occur as they do throughout Central America (3–10).

Social stability affects health, be it the development of a volunteer paramedic corps such as the *brigandistas* or the eruption of conflict such as the Sandanista-*contra* war of Nicaragua or the civil war of El Salvador. The latter involved the closure of the National University from 1980 to 1984. During the counterinsurgency campaigns of Guatemala in the 1980s, approximately 180,000 persons disappeared, including 500 health promoters. One consequence of such turmoil is sustained levels of malnutrition in these and neighboring countries (11,12). UNICEF reported, before Hurricane Mitch, that 12,000 Honduran children die yearly from malnutrition.

Three disease phenomena to consider when assessing Central American health include the heterogeneity of diseases, the limitation of data sources, and the effect of political strife. The heterogeneity of disease is illustrated by acquired immunodeficiency syndrome (AIDS), a syndrome that affects residents throughout Central America. Highest caseloads occur in Honduras, but the epidemiology of AIDS there is more akin to that of the Caribbean or Africa (heterosexual spread, male:female sex ratio approaching 1:1). High caseloads and the equal sex ratios for Honduras reflect a predominantly heterosexual mode of transmission of the human immunodeficiency virus (HIV), perhaps because of geographic proximity to the Caribbean and considerable prostitution in the cities. In the rest of Central America, the epidemiology is similar to that of the United States (13). Hence, labeling Central Americans with a single disease or syndrome requires recognizing the chance of such heterogeneity.

Limitations of local databases are best illustrated by cancer data that may reflect ongoing programs more than actual status of disease. For example, past Central American cancer data showed unusually high amounts of cervical cancer. While this could be due to locally prevalent risk factors (early age of first sexual activity, increased number of partners), local research interests and surveillance activities could bias the ordering of data (14). Only by recognizing "age stratified mortality and population figures of sufficient detail" can we reasonably assess such databases.

Political strife is evident in the arena of mental health problems. The political turmoil of war-related trauma, such as displacement, loss of loved ones, persecution, and torture with civil strife, are all significant factors that affect the mental health of many current Central American immigrants.

Studies on Central American immigrants in the United States include occasional parasitologic surveys (15–18); serosurveys for *Trypanosoma cruzi*, the causative agent for Chagas' disease, in which about 5% were positive in 1987 (19); and screening studies for tuberculosis (TB) (20,21), including one showing skin positivity rates as high as 81% among Guatemalan-born children in San Francisco (22). A Houston survey, published in *Texas Medicine*, among recently arriving immigrant Central Americans showed a tuberculin skin test reactivity rate of 57% (20). Mental health analyses include surveys of 133 detained Central American juveniles, aged 13 through 17 years, at 2 South Texas Immigration and Naturalization Service detention centers. More than half the detainees reported 4 or more traumatic events, including murder of family member, threats, encountering cadavers, forced recruitment, and rape (2,23).

METHODS

A retrospective cohort study was performed. Hospital district utilization patterns of Central American natives cared for at HCHD facilities between April 1, 1994, and September 30, 1995, were compared with utilization patterns of the remaining population. Primary diagnoses were based on the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM). Codes used to define diagnostic categories are available from author WS.

Central Americans were identified by place of birth as recorded in HCHD registration. Data were obtained from the Information Systems Division, HCHD, in summary form, based on number of patient visits rather than on number of patients. Patients were asked at registration to self-identify themselves if "undocumented." Human error was accounted for by including abbreviations, misspellings, and permutations of Central American country names.

Selection of diagnoses used for statistical comparisons among groups was based on knowledge of likely problems in the community and encompassed 7 categories: infectious diseases (including sexually transmitted diseases [STDs], positive HIV status and AIDS, TB, intestinal parasites, and vector-borne diseases); neoplasms; chronic diseases (including hypertension, heart disease, cerebrovascular disease, diabetes mellitus, and senile dementia); uncomplicated births; complications during pregnancy, labor, delivery, or

puerperium; congenital anomalies; adverse birth outcomes or sudden infant death syndrome; and mental health problems.

The chi-squared tests for R x C contingency tables and 2-sample tests for binomial proportions were performed. The Bonferroni correction for multiple comparisons was applied as appropriate. For the R x C contingency tables, a P value = 0.007 (0.05 with 7 comparisons) was deemed significant. For the 2-sample tests for binomial proportions, a P value = 0.0005 (0.05 with 105 comparisons) was deemed significant. When expected values were less than 1 for a given group and category, values were omitted from individual tables (24,25).

RESULTS

Among more than 1 million recorded patient visits to HCHD facilities, the self-reported nationality was Central American for 2.6% and Salvadoran for 2.2%. An undocumented status was reported for 39.4% of visits by Central Americans. When birthplace data were used, 4.4% of all patient visits were by Central Americans and 47.3% were by undocumented persons (Fig 1). The male:female ratio was 0:28 for all Central Americans and higher than 1 (1.1) only for Belizeans. The mean age was 33.9 years, ranging from 33.0 years for Hondurans to 51.2 years for Belizeans. Houston treatment facilities caring for this population cluster in the geographic areas where Central Americans reside, with only Belizeans favoring a clinic used by the African American community. The most common diagnoses on presentation by Central Americans, by number of visits, are shown in Table 1. Utilization rates based on 7 compiled diagnostic categories are presented in Table 2. Statistically significant differences were seen between observed frequency of visits for non-

Fig 1. Percentage of visits by Central Americans, by nationality.

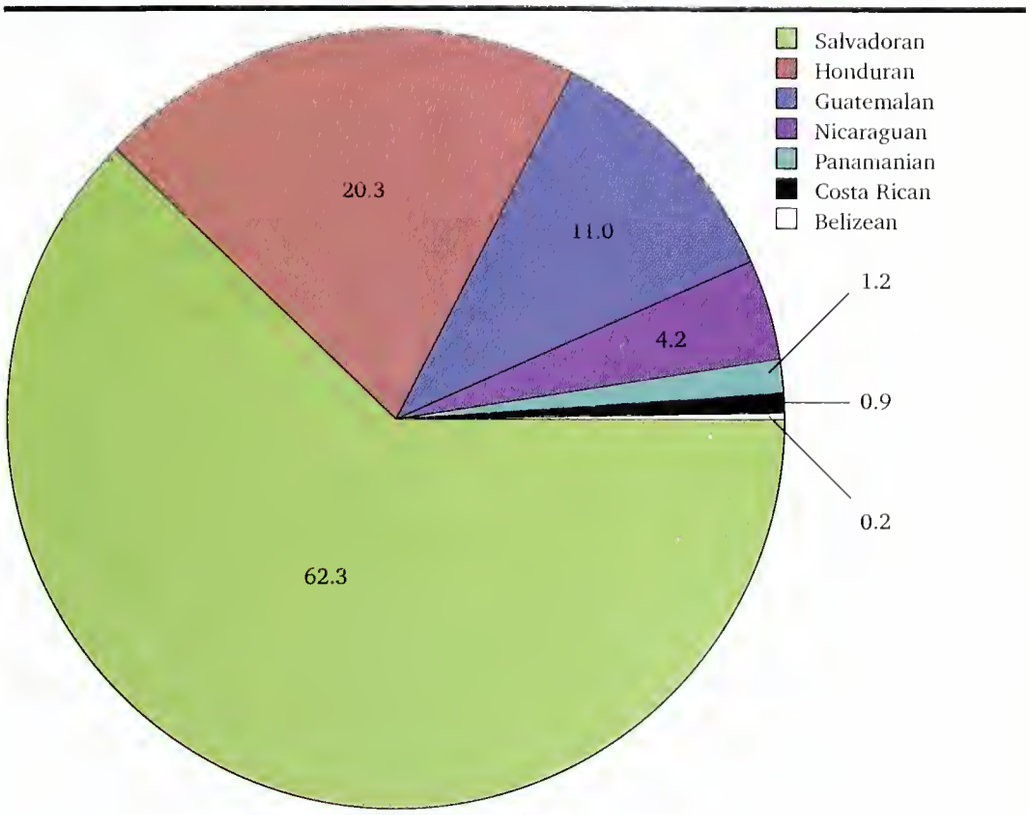

Table 1. Most common diagnoses for Central American visits to Harris County Hospital District from April 1994 through September 1995.

Diagnosis	No. of Visits
1. Follow-up clinic evaluation	1921
2. Supervision of pregnancy	1366
3. Hypertension	1279
4. Complications of prior care	989
5. Follow-up for surgical care	881
6. Normal delivery	841
7. Routine gynecologic examination	821
8. Abdominal pain, unspecified	786
9. Allergic rhinitis	780
10. Diabetes mellitus, type 2	767
11. Urinary tract infection	753
12. Acute upper respiratory tract infection	707
13. Headache, unspecified	686
14. Vaginitis	608
15. Diabetes mellitus, antepartum	606
16. Lumbago	584
17. Delivery complicated by first-degree laceration	549
18. Ocular refraction	531
19. Antepartum complications	527
20. Myalgia and/or myositis	522

Table 2. Observed versus expected visits to Harris County Hospital District, by nationality and diagnostic category.

	Observed and [Expected] No. of Visits, by Nationality							
Diagnostic Group	Salvadorans	Hondurans	Guatemalans	Nicaraguans	Panamanians	Costa Ricans	Belizeans	Non-Central Americans
Infectious diseases	3658 [4215]	1377 [1580]	733 [776]	302 [279]	56 [77]	62 [51]	13 [20]	162,636
Neoplasms	542 [560]	170 [209]	90 [103]	28 [37]	23 [10]	10 [7]	1 [3]	21,555
Chronic disease	2225 [4460]	687 [1680]	341 [827]	170 [298]	76 [82]	38 [54]	34 [21]	163,745
Uncomplicated deliveries	347 [82]	175 [29]	59 [14]	9 [5]	1 [1]	0	0	2,885
Complications of pregnancy, labor, and delivery	4264 [1423]	1779 [517]	807 [250]	204 [89]	30 [25]	16 [16]	5 [6]	51,878
Congenital abnormalities, adverse fetal outcome, and SIDS	110 [130]	6 [48]	6 [24]	14 [9]	1 [2]	1 [2]	0	5,025
Mental health disorders	443 [713]	140 [268]	72 [132]	37 [47]	24 [13]	11 [9]	0 [3]	27,679

SIDS = sudden infant death syndome

The expected values assume a distribution equivalent to the non-Central American population.
Chi square, distribution of diagnoses, non-Central Americans versus:

Salvadorans = 8037, $P < 0.0001$
Hondurans = 4566, $P < 0.0001$
Guatemalans = 1711, $P < 0.0001$
Nicaraguans = 216, $P < 0.0001$
Panamanians = 33, $P < 0.0001$
Costa Ricans = 10, $P < 0.085$
Belizeans = 15, $P < 0.0005$

Central American patients versus all Central American nationalities at $P < 0.005$ except for Costa Ricans.

Central Americans had lower visit rates for infectious diseases (Table 3); Salvadorans and Panamanians showed the smallest percentages. For tropical diseases, we had only 13 visits (9 patients) for malaria but no diagnosed or reported encounters for dengue or leptospirosis. The most common major infection was TB (280 encounters among 85 patients).

For STDs (not including HIV infection or AIDS), utilization rates were 80% higher among Central American natives (14.7 vs 8.2 per 1000 visits, $P < 0.0001$; this and all subsequent comparisons are presented per 1000 visits, P value by binomial proportions), a difference most pronounced for Salvadorans and Nicaraguans (16.3 and 16.3). Central Americans had significantly lower visit rates as a group for HIV and AIDS (7.7 vs 21.3) and the only nationality whose visit rate for HIV/AIDS approached that of non-Central Americans was Honduran (17.3, $P < 0.0001$). The visit rates for TB and its complications among Central Americans differed minimally from those of non-Central Americans (4.9 vs 4.3, $P = 0.048$), although only Guatemalans had significantly higher visit rates for active TB (8.5, $P < 0.0001$). Visit rates for parasitosis were not increased (2.9 vs 3.2, $P = 0.27$).

Central American immigrants had proportionately fewer visits for neoplasms (18.6 vs 21.4, $P < 0.0001$) and chronic diseases (7.7 vs 17.3, $P < 0.0001$), including hypertension (23.8 vs 70), heart disease (7.4 vs 20.1), and diabetes (33.4 vs 57.5). Rare isolated exceptions were noted (eg, among Belizeans, the rate for hypertension was 93.8).

The most significant differences in rates were for uncomplicated deliveries, which occasioned a hospital visit almost 5 times more often for Central American immigrants than for non-Central Americans (Table 3). Central Americans accounted for 17.5% of all visits for uncomplicated deliveries at HCHD facilities. The increased visit

Table 3. Central American utilization of Harris County Hospital District facilities for infectious diseases and [uncomplicated deliveries], by nationality (n).

Nationality	No. of Visits	Rate (per 100 visits)	Odds Ratio	Z	*P*
Non-Central Americans (1,006,597)	162,636 [2781]	16.2 [2.8]	1 [1.0]		
Central Americans (46,371)	6,201 [591]	13.4 [12.8]	0.83 [4.57]	16 [-37.2]	<0.0001 [<0.0001]
Salvadorans (28,872)	3,658 [347]	12.7 [12.0]	0.78 [4.20]	15.9 [-28.3]	<0.0001 [<0.0001]
Hondurans (9,416)	1,377 [175]	14.6 [18.6]	0.9 [6.64]	4 [28.4]	<0.0001 [<0.0001]
Guatemalans (5,076)	733 [59]	14.4 [11.6]	0.89 [4.14]	3.3 [-11.9]	0.0009 [<0.0001]
Nicaraguans (1,964)	302 [9]	15.4 [4.6]	0.95 [4.6]	0 [-1.5]	0.35 [0.13]
Panamanians (540)	56	10.4	0.64	3.7	0.0003
Costa Ricans (407)	62	15.2	0.94	0.5	0.61
Belizeans (96)	13	13.5	0.83	0.7	0.49

The odds ratios were calculated as visit utilization rates for a given nationality/visit utilization rates for all non-Central Americans.
Z values were determined with the 2-sample test for binomial proportions.
Significant *P* values using Bonferroni adjustment for multiple comparisons were all values less than 0.0005 (the new critical value).

rate was significant for Salvadorans, Hondurans, and Guatemalans.

The visit rates for complications of pregnancy, labor, delivery, and puerperium were similarly higher among Central American natives (15.3 vs 5.2, $P < 0.0001$), although the visit rates for congenital anomalies, adverse fetal outcomes, and sudden infant death syndrome were significantly lower compared with non-Central Americans (3.5 vs 5.0, $P < 0.0001$).

Central American immigrants from the 4 nationalities most represented in Houston had significantly lower visit rates than non-Central Americans for mental health disorders (15.7 vs 27.5, $P < 0.0001$), pediatric mental health disorders (emotional disorders, hyperactivity, and developmental delay) (0.3 vs 1.2, $P < 0.0001$), and alcoholism and drug dependence (1.9 vs 8.4, $P < 0.0001$). Panamanians alone among Central Americans had a higher visit rate for mental health disorders (44.4, $P = 0.016$).

DISCUSSION

The relative youth of Central American immigrants accounts for high visit rates for STDs and uncomplicated deliveries, and, conversely, for low rates for chronic diseases. The higher median age and unique ethnicity of Belizeans account for their singularly high visit rates for chronic diseases, especially hypertension.

Birthplace was a more reliable measure of Central American origin than was nationality. Many immigrants become naturalized, others deny citizenship, while others feign citizenship in a country granted amnesty privileges by the United States. For example, a Salvadoran origin represents an asset in that the US government officially recognized the civil war of El Salvador but not other very significant recent disturbances in Central America.

The TB data merit 2 comments. Data analyses using birthplaces reflect often ongoing programs and, thus, an observed high frequency of visits for TB screening programs (data not shown) was merely the result of immigrant screening projects. Furthermore, utilization data require analysis in view of demographics. For example, most Central American patients fail to show higher

visit rates for active TB either because they may fail to seek care for active TB or, more likely, this young population has been exposed but has yet to progress to active disease (20–22).

Other tropical diseases were seen infrequently despite reports confirming recent outbreaks of common tropical diseases. The cholera outbreak that began in Peru in 1991 affected residents of all Central American nations; an outbreak of leptospirosis occurred predominantly among Nicaraguans; and Belizeans, in conjunction with the peoples of the Caribbean, suffered from recent outbreaks of dengue and dengue hemorrhagic fever (26). The absence of these diagnoses among our immigrant population may result from the epidemic nature of these infections.

We do not imply that prevention programs should be modified on the basis of this type of data. Consider parasitic diseases, whose infections may be asymptomatic. They will not be accounted for when utilization rates are assessed, and screening programs for parasites show public health validity (27). A recently published article documents the cost-effective validity of treating immigrant populations with a 5-day course of albendazole and suggests that, in the future, empiric treatment of immigrants may be preferred over screening for parasites. Utilization data also may fail to detect less readily diagnosable entities such as malnutrition, which is better assessed with specific screening programs (eg, those of the Pan American Health Organization, which document significant iodine and vitamin A deficiency and reduced height for weight indices among Central American natives) (3,7,29).

The high frequency of visits for STDs, in conjunction with known low rates for barrier contraceptives and high rates for prostitution, emphasizes the need for targeting sex education programs and intensifies STD control programs among immigrant communities. That HIV and AIDS visit rates were not increased may reflect the lower prevalence of HIV infections in Central America. However, AIDS prevention programs are advisable in view of the high fertility and sexual activity of the population (30–32).

Low utilization rates for mental health service are unexplained in view of Central American experiences with war-related trauma, the difficult journey to the United States, and post-traumatic stress disorder (12,33). Immigrants may only seek available public mental health services reluctantly, finding instead solace from compatriots, from the church, or from Hispanic nongovernmental organizations with a common cultural background insight into unique wartime and journey experiences.

Specific conclusions can be drawn cautiously. Visit rates may not reflect actual health status. Determining incidence or prevalence of disease requires knowledge of denominators, in this case the unknown population sizes of local Central American communities. Use of visits rather than individual patients skews findings for certain diseases and conditions. A single patient with a high-risk pregnancy or chronic illness and repeated visits, for example, could inflate visit rates for that diagnostic entity. Finally, only public facility data were analyzed. Earlier immigrants may use private care, recent immigrants may frequent free nonpublic clinics, and both may resort to alternative forms of medical care.

The long-term effects of the 1998 natural disaster with Hurricane Mitch are unknown (see Addendum). A potential effect on migration is a consideration, as reported by a popular news columnist (34), because climatic events are known to affect migration patterns. (For example, African migrations are often magnified during extensive droughts in the Sahel. The Dust-bowl migrations in the United States were incited by weather phenomena.) Nonetheless, the Central American climate is usually agreeable throughout the year. Furthermore, Hurricane Mitch is but one of many tragic events within the recent tumultuous history of the Central American nations (35). Because the magnitude and severity of this hurricane may impact the economic output and chronic level of Central American medical care and services, immigrants from the severely impacted nations of Honduras and, less so, of Nicaragua unfortunately will continue to show the compromised health indices that characterize their health care systems.

Despite such limitations, these data do show that in the care of immigrants from Central America, the most common diseases are those associated with youth and sexual activity. Tropical diseases do need to be considered in the care of individual patients. However, Central Americans seeking care in the public sector infrequently present for mental health care; they show an increased rate of complicated pregnancies; and their low utilization of services for HIV infections reflects the lower prevalence of HIV in Central America compared with that in the United States. Services needed for this growing segment of the community in Texas and in all likelihood other American destinations for these immigrants include STD clinics and prenatal and obstetric services.

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ADDENDUM

The devastation wreaked in November 1998 by Hurricane Mitch on the Central American nations is impacting significantly the physical and psychological health of the residents of Honduras, Guatemala, El Salvador, and Nicaragua. Undoubtedly, a consequence of the economic and social havoc imposed by this tragedy will be increased immigration of the residents of these nations to the United States. The death toll is estimated at 9000 to 11,000; approximately 2 million people were left homeless (referred to locally as *damnificados*). Honduras clearly was the most severely impacted; whole villages were decimated in the eastern portion of the country as the river surged through the countryside. In addition, seismic activity is increasing in the region affected by the hurricane, and residents are subjected almost weekly to earthquakes of varying magnitude.

The outpouring of support — financial, physical, medical, and emotional — is considerable. While much of the American monetary support depends on congressional willingness to support President Clinton's offer of $950 million in aid to rebuild the roads, bridges, and clinics in the affected nations, a number of agencies continue to provide direct support to Central American nations in recovery (see list of agencies and addresses for donations).

Numerous organizations and churches are adopting sister cities or institutions in Central America, such as the tie between Covenant House and Casa Alianza noted in the accompanying list. Two Houston-based churches have established such alliances — Salem Lutheran Church of Tomball with a mission in San Juan Pueblo in northern Honduras, and Prince of Peace Catholic Church of Tomball with a church in Santa Cruz del Quiché in the Guatemalan highlands.

Agencies providing support to Central America

Covenant House (allied with Casa Alianza in Central America)
SJO 1039
PO Box 025216
Miami, FL 33102

Central American Refugee Center of Houston
6006 Bellaire
Houston, TX 77081

Asociación de Guatemaltecos
AGU/Hurricane Emergency
Washington Mutual Bank
3438 Fruitvale Ave
Oakland, CA 94602

American Friends Service Committee
1501 Cherry St
Philadelphia, PA 19102

Catholic Medical Mission Board
10 W 17th St
New York, NY 10011

Center for the Study of Americas
2288 Fulton St
Office 103
Berkeley, CA 94704

Quest for Peace
Hurricane Fund
PO Box 5206
Hyattsville, MD 20782

Committee of Solidarity with the People of El Salvador
PO Box 1801
New York, NY 10159

Nicaragua Network
1247 E St SE
Washington, DC 20003

Texas Physicians' Directory

Allergy

Corpus Christi Allergy & Asthma Center
James A. Caplin, MD
AAA, ACA, AACIA

Allergy, Asthma, and Clinical Immunology
2250 Morgan Avenue, Corpus Christie, Texas 78405
Telephone (512) 888-6782

Anesthesiology

Gonzales & Sanchez, PA
Diagnostic and Therapeutic Preventive Healthcare
Anti-Aging Medicine

Justo J. Gonzales, MD, FACA
Diplomate American Academy of Pain Management
Evaluation, diagnosis, and treatment of acute, chronic, and recurrent pain
Differential, diagnostic, and therapeutic nerve blocks
Spinal cord stimulation
Implantable intraspinal narcotic pumps

Xochitl B. Sanchez, MD
Diplomate American Board of Anesthesiology
Anesthesiology
7777 Forest Lane
Suite C-538
Dallas, Texas 75230
(972) 566-4890
Answered 24 hours
Fax (972) 566-4894

Edward A. Talmage, MD, FACPM
Diplomate American Board of Anesthesiology
Fellow American College of Pain Medicine

INTERVENTIONAL PAIN MEDICINE
Diagnostic & Therapeutic Nerve Blocks
Neurolytic Procedures
Neuromodulation
Radio Frequency Lesioning
Suite 403, West Houston Doctors Center, 12121 Richmond Avenue, Houston 77082;
(281) 496-1006

Bariatric Surgery

Ira J. Kasper, M.D., P.A.
General, Vascular & Bariatric Surgery
American Society of Bariatric Surgery
Diplomate American Board of Surgery
Surgery for Morbid Obesity & Co-Morbid Conditions
5420 Dashwood, Suite 201, Houston, Texas 77081
(713) 667-9100 Fax (713) 667-9133

Dermatology

Robert F. Bloom, MD
Mohs Surgery for Skin Cancer
Dermatologic Surgery
Malignant Melanoma
Dysplastic Nevi
Cutaneous Oncology
2201 Oxford Avenue, Suite 204
Lubbock, Texas 79410; (806) 797-6631

Gynecologic Oncology

Mark G. Doherty, MD, FACOG, FACS
Malignant and Premalignant Female Genital Disease
Texas Oncology, P.A.
7940 Floyd Curl Drive, Suite 720
Medical Center Tower II
San Antonio, Texas 78229
(210) 692-1918, Fax (210) 692-7379
Doctor's only toll-free (888) 614-2400

Hand Surgery

David J. Zehr, MD — Microsurgery
Arnold V. Dibella, MD — Wrist Derangements
Paul R. Ellis, MD
Diplomates American Board of Orthopaedic Surgery
Hand Surgery and
Upper Extremity Reconstructive Surgery
3600 Gaston Ave., Suite 450, Dallas, Texas 75246; (214) 823-5351
LANKFORD HAND SURGERY ASSN.

Medical Toxicology

OCCUPATIONAL AND ENVIRONMENTAL TOXICOLOGY

Eric G. Comstock, MA, MD

Diplomate, American Board of Medical Toxicology
Fellow, American College of Medical Toxicology
Fellow, American Academy of Clinical Toxicology
Fellow, American College of Occupational and Environmental Medicine

Consultation by appointment
6910 Bellaire Blvd., Suite 12
Houston, TX 77074
Telephone (713) 541-3214 Fax (713) 271-6508

Neurological Surgery

Drs. Smith and Wheeler

Ronald Smith, MD, Deceased
Joe Ellis Wheeler, MD

750 Eighth Avenue Place, Suite # 530
Fort Worth, Texas 76104
Telephone (817) 335-3966

Ophthalmology

Louis M. Alpern, MD, MPH, FACS, PA

Diplomate American Board of Ophthalmology
Diseases and Surgery of the Eye

2201 North Stanton, El Paso, Texas 79902
For both locations:
1030 North Zaragosa Road, Suite Y, El Paso, Texas 79907 (915) 545-2333

Orthopedic Oncology

Mayme F. Richie-Gillespie, MD

Diplomate American Board of Orthopaedic Surgery
Fellowship Trained in Orthopaedic Oncology
Orthopaedic Surgery-Oncology Limb Salvage Surgery
Metastatic Bone Disease Osteomyelitis
The Bone and Joint Clinic, L.L.P.
1651 W. Rosedale, Suite 100 (817) 335-4316
Fort Worth, Texas 76104 http://home.swbell.net/fracture

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Robert D. Vandermeer, MD
R. Stephen Curtis, MD
William A. Bruck, MD
W.Z. Burkhead, Jr., MD
Richard D. Schubert, MD
John A. Baker, MD
James R. Sackett, MD
Daniel E. Cooper, MD
Paul C. Peters, Jr., MD
Andrew B. Dossett, MD
Eugene E. Curry, MD

A Professional Association
2909 Lemmon Ave., Dallas, Texas 75204-2385; (214) 220-2468; Fax (214) 720-1982

ORTHOPEDIC ASSOCIATES OF DALLAS, L.L.P.

John B. Gunn, MD
Huntly G. Chapman, MD
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James M. Lancaster, MD
James W. Brodsky, MD
Kurt W. Rathjen, MD
Craig C. Callewart, MD
Kenneth A. Stephenson, MD
Robert G. Viere, MD
Thomas C. Diliberti, MD

Orthopedic Surgery
Landry Towers, 411 North Washington, Suite 7000, Dallas, Texas 75246; (214) 823-7090
Medical City Dallas II, 7777 Forest Lane, Suite B116
Dallas, Texas 75230; (972) 556-7010

THE BONE & JOINT CLINIC

1651 West Rosedale, Fort Worth, Texas 76104; (817) 335-4316
http://home.swbell.net/fracture

Joseph H. Gaines, MD, PA
Stephen L. Brotherton, MD, PA
Mayme Richie-Gillespie, MD, PA
Steven J. Mackey, MD, PA
Joseph C. Milne, MD, PA

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Emeritus Chairman Hospital for Sick Children, Toronto
Exclusively children's orthopedics, bone tumors of children, scoliosis, Ilizarov lengthening, congenital deformities

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(972) 566-6700

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JOHN A. SAZY, MD
Reconstructive Spine Surgery
Revision Spine Surgery
Scoliosis Surgery
General Orthopedics

Fellowship: The Chicago Spine Fellowship
Director: R.L. Dewald, MD
3217 Omega Drive, Arlington, Texas 76014; (817) 468-4422; Fax (817) 468-7676

Pain Management

PRAFUL SINGH, MD
Pain Specialty Consultants, PA
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Subspecialty Certification in Pain Management
by American Board of Anesthesiology
Fellowship in Pain Management
Diplomate American Board of Anesthesiology
Full-time Pain Practice Based on Multidisciplinary Concepts

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San Antonio, Texas 78212
540 Madison Oak, #210
San Antonio, Texas 78258; Telephone (210) 527-1166

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Pain Management Center at Presbyterian Hospital of Plano
6200 W. Parker Road, MOB-I, Suite 412, Plano, Texas 75093;
Phone (972) 608-8592; Fax (972) 608-8462

Physical Medicine & Rehabilitation

ROBERTO G. ROLFINI, MD
Diplomate American Board of Physical Medicine & Rehabilitation
Rehabilitation Medicine and Electromyography

102 Rosa Verde Tower, 343 W. Houston Street
San Antonio, Texas 78205; Telephone (210) 226-2424

Radiation Oncology

J. CARLOS HERNANDEZ, MD
Clinical Associate Professor, UTHSC-SA

Gamma Knife Radiosurgery for primary and metastatic brain tumors
Peacock (intensity modulated) Radiotherapy for primary brain tumors
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LDR and outpatient HDR (Selectron) implants for gyn and lung tumors
3D Conformal Radiotherapy

Cancer Therapy and Research Center
7979 Wurzbach Road, San Antonio, Texas 78229
(210) 616-5688; Fax (210) 616-5613

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TexasMedicine

Don't miss one word of the July issue of *Texas Medicine.*

WE'LL EXPLORE:

Physician workforce issues
Disaster response
Causes of child mortality
TexMed '99 actions

For more information, call Larry BeSaw, managing editor, at (800) 880-1300, ext. 1383, or (512) 370-1383, or e-mail larry_b@texmed.org. Also consult the TMA Web site at www.texmed.org.

Classified Directory

OPPORTUNITIES AVAILABLE

Anesthesiology

Anesthesiologist/Board Certified Pain Management needed for office work in Dallas/Fort Worth. Contact Lisa Abell at K Clinic, (888) K CLINIC or fax CV to (972) 256-1882.

Emergency Medicine

Beautiful East Texas

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TEXAS: Regional emergency group has held 20-year contract to staff nationally recognized ED. Contracts range from 14,000-60,000 pt visits annually. Earn excellent compensation as an independent contractor without the day-to-day hassles of managing your own practice. Fax (817) 496-9889 or send CV to:

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Fort Worth TX 76112

Longview, Texas – FT/PT Emergency Medicine experienced BC/BP primary care physicians needed to work with locally owned independent group. Located in East Texas, the community of Longview (80,000+ residents) has excellent schools and an abundance of outdoor activities while retaining the convenience of nearby Dallas and Shreveport. The position offers a competitive rate to staff, a 20,000+ visit, minor emergency center located within the hospital ED. For more information, please call PSR@(800) 346-0747, ext. 113.

Family/General Practice

STAFF PHYSICIANS

Texas A&M University is seeking a qualified physician to work in the student health care facility providing primary care to students. Requires medical degree, state of Texas medical license and experience with private or group medical practice or equivalent. Salary is negotiable, with excellent benefit package including liability coverage. Send a resume and letter of interest with list of three references to:

Employment Office
Human Resources Department
Texas A&M University
College Station, Texas 77843-1475

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Need FP or ER physician to work in minor emergency/OC-med clinic, 60 miles north of Dallas. Excellent staff, well-equipped, malpractice paid. No hospital. No call. Send CV to Medical Care Center, 301 N. Grand, Gainesville, TX 76240; phone (940) 665-0736 (O), (940) 668-8842 (H), (940) 727-2625 (cell).

Family Practice Available to the right candidate. No investment needed! Board Certified FP or IM physician is needed for small group practice. Two physicians retiring. Beautiful professional building adjacent to Charlton Methodist Hospital, DeSoto, Texas, just south of Dallas. Rapidly growing suburban community with the amenities of the city and the calm space of the country. Call Brad McCarty at (972) 298-4535 or fax CV to (972) 296-4473.

Primary Care Physician: Large established group seeks full time family practice/internist to man our satellite clinic in deep East Texas. Excellent location in close proximity to Houston and Dallas, good public schools and beautiful recreation area of lakes and golf courses. Excellent salary and benefits package. Not HPSA area. Reply to Ad-1206, Texas Medicine, 401 W. 15th St., Austin, TX 78701.

Austin, Texas—Employed position available immediately in well established primary/urgent care clinics. Board certified family practice physician preferred. Full time/part time. Flexible scheduling. Salary and benefits. J-1 visa not available. Please send your CV to: Brennan McNally, PO Box 1788, Austin, Texas 78767-1788; or fax to (512) 482-4167.

FAMILY MEDICINE

The University of Texas Medical Branch Conroe Family Medicine Residency Program needs an experienced board certified family medicine faculty member (non tenure track, clinical). Experience should include obstetrics, teaching, and a minimum of two years practice experience. Must have a Texas license. Our program is accredited and has 21 residents. Conroe is a beautiful suburban community located only 40 miles north of Houston. UTMB is an EO/AA employer M/F/D/V. UTMB is a smoke free/drug free workplace. UTMB hires only individuals authorized to work in the United States.

Please respond by contacting
Joseph G. Ewing, M.D., Program Director,
University of Texas Medical Branch,
701 E. Davis, Suite C, Conroe, Texas 77301.

Applications accepted until position is filled.

Family/General Practice

UTMB
The University of Texas Medical Branch at Galveston

ASSISTANT/ASSOCIATE PROFESSOR
The Department of Family Medicine is seeking a Geriatric focused family physician for the following position:

CLINICAL/TEACHING GERIATRICIAN FACULTY
Responsibilities include teaching in the predoctoral and residency training programs, as well as direct patient care in the ambulatory, in-patient and nursing home settings. The department operates a large residency program, a required third-year medical student clerkship, a large state-of-the-art clinical practice with an electronic medical record system, and provides leadership in the Robert Wood Johnson Generalist Physician Initiative program for community-based education.

Responsibilities include opportunities to participate in research projects in the areas of medical decision making, medical outcomes, clinical effectiveness, palliative care, and end of life issues are available.

Candidates should have a CAQ in Geriatrics and a minimum of three years post-residency experience, be board-certified, and qualify for medical licensure in Texas. Salary and appointment level will be commensurate with training and experiences. Please send letter of interest and curriculum vitae to:

Barbara L. Thompson, MD, Chairman
Department of Family Medicine
The University of Texas
Medical Branch at Galveston
301 University Blvd.
Galveston, Texas 77555-1123
Fax: (409) 747-6011

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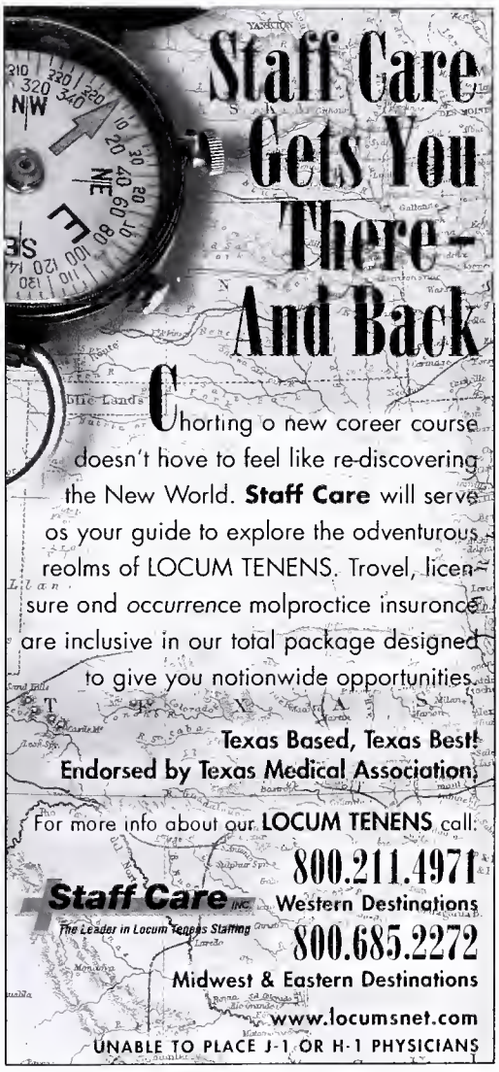

Neurosurgery

GAMMA KNIFE NEUROSURGEON
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W. Robert Hudgins, M.D.
Neurological Surgeons of Dallas, P.A.
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(214) 691-2111 ◆ FAX (214) 691-3799
Email: doctor@drhudgins.com

OB/GYN

OB/GYN Practice—Two female group seeking a third doctor. Please contact office manager, Southside Women's Center, PA, 5920 Saratoga Blvd., Ste. 570, Corpus Christi, Texas 78414. Call (361) 985-8100. Offices are set up to receive third doctor.

Radiology

WANTED: Board Certified general Diagnostic Radiologist w/interest in Mammo/US/CT for outpatient imaging. No interventional procedures. Benefit package, permanent position. Send CV in confidence PO Box 241000, San Antonio, TX 78224.

RADIOLOGIST VACANCY

The North Texas Veterans Health Care System Radiology Service will have an opening in September 1999 for a GI radiologist at its state-of-the-art Dallas facility. Applicant should be skilled in all aspects of diagnostic GI radiology.

This position includes an academic appointment with its affiliate, The University of Texas Southwestern Medical Center. It also has a very active residency program.

Applicants must be a U.S. citizen and must possess an active current license to practice radiology in a State, Territory or Commonwealth of the United States, or in the District of Columbia.

Applicants should forward a curriculum vitae and references to:

Ward M. Terry, M.D.
Chief, Radiology Service (114)
Department of Veterans Affairs
Medical Center
4500 South Lancaster Road
Dallas, TX 75216
(214) 857-0185
(214) 857-0173 (FAX)

An Equal Opportunity Employer
Applicants Subject to Drug Testing
Non-Smoking Facility

Other Opportunities

Kelsey-Seybold Clinic and the Johnson Space Center announces the opening in their Occupational Medicine Clinic. The physician must have prior military/Flight Surgeon experience in either the U.S. Air Force or Navy. Aerospace Medicine Board Certification/Primary Care specialty is desirable. The individual must excel in ambulatory care medicine as well as be trained in flexsigmoidoscopy. Excellent interpersonal skills a must. A Texas license is required. If you have the "right stuff," fax your CV c/o A. C. Rossum, MD, (281) 244-5179.

Wanted: BC/BE Internists, FPs, Psychiatrists, and other subspecialties for Moonlighting opportunity in several locations across Texas. $60-80/hour. Please call Quality Care Medical Group, (210) 614-3063.

OKLAHOMA PRACTICE OPPORTUNITIES

McAlester Regional Health Center, McAlester, Oklahoma is recruiting the following specialties: Pediatrics, Obstetrics-Gynecology, Cardiology, Pulmonary Medicine, Ophthalmology, Nephrology, Dermatology and Infectious Disease. Competitive net income guarantees, student loan assistance, equipment loans and full marketing support. McAlester is not a J-1 visa area. Contact: Vicki Schaff, Director Physician Services/ Recruitment, (800) 319-2455, Fax.(918) 421-8066, E-mail: vschaff@mrhc.mcalester.ok.us.

PRIVATE PRACTICE OPPORTUNITIES
(in all specialties)
Texas & Sunbelt States
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Or send CV to:
PO Box 42314
Houston, TX 77242-2314
FAX 281-493-2234

Reuben Bronstein & Associates

TEXAS MEDICINE CLASSIFIED DIRECTORY DEADLINES

ISSUE	DEADLINE
August 1999	**July 1, 1999**
September 1999	**July 30, 1999**
October 1999	**September 1, 1999**

Methodist Hospitals of Dallas

HEMATOLOGY/ONCOLOGY

A small single-specialty oncology group affiliated with Methodist Hospitals of Dallas seeks a third physician to join their private practice group. New Cancer Centers with advanced technology. Competitive salary and benefits with 1:3 call.

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Excellent opportunity for a BC/BE otolaryngologist to provide general ENT services in SW Dallas County. Nice, progressive hospital facilities nearby. Incoming physician would preferably associate with an established practitioner in the area or consider establishing a solo practice with hospital support.

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Seven physician, all board certified cardiology group seeks two additional cardiologists (electrophysiologist, non-invasive cardiologist) to join this well-established, busy practice. A recently completed Heart Center and "EP" lab enhance patient care services. Methodist serves SW Dallas County including the DeSoto, Cedar Hill, Duncanville, Grand Prairie, and Lancaster communities.

Please forward CV to Susan Cogburn, Physician Recruiter c/o Methodist Hospitals of Dallas, PO Box 655999, Dallas, TX 75265. Phone (214) 947-4579, fax (214) 947-4502, e-mail: susancogburn@mhd.com.

Other Opportunities

METRO HEALTH
SAN ANTONIO'S PUBLIC HEALTH TEAM

SENIOR PUBLIC HEALTH PHYSICIAN SAN ANTONIO

The San Antonio Metropolitan Health District is currently recruiting for a Senior Public Health Physician. Responsibilities include performance of clinical services and supervision of professional medical and technical staff. Focus of this position is on infectious disease public health programs. Direct patient care, in addition to management of public health programs, is required. Consultation with medical and epidemiology staff internally and externally is essential to include contact with the Texas Department of Health (TDH), Texas Centers for Infectious Disease (TCID), and the U.S. Centers for Disease Control and Prevention (CDC).

Requirements: Graduation from an accredited medical or osteopathic college. Residency training and, as a minimum, board eligibility in a medical specialty plus, at least two (2) years experience in a relevant clinical practice setting. Residency and experience in infectious disease, internal medicine, pediatrics, or preventive medicine is preferred. Experience in treating tuberculosis and STD patients is highly desirable. Must possess a current valid license to practice medicine in the State of Texas upon employment. Interested individuals should submit their applications/resumes to The San Antonio Metropolitan Health District, Personnel Coordinator, 332 W. Commerce, San Antonio, Texas 78205.

Please call Richard N. Condra at (210) 207-8732 if you have any questions.

POSITIONS WANTED

Board Certified OB/GYN with a recent Texas license by endorsement seeking to join a group practice or another OB/GYN in a partnership after 14 years of solo practice in the Midwest. I am willing to come in as an employee or to buy into the practice. If interested please contact me at 1827 Paces River Ave., 13-101, Rock Hill, SC 29732; phone number (803) 324-5138.

Family physician residency trained with 10 years experience in family practice, desiring relocation in Texas. U.S. citizen. Texas licensed. Please reply to Ad-1207, Texas Medicine, 401 W. 15th St., Austin, TX 78701, or call (800) 556-9965. No recruiters.

Internist and Family Practitioner with excellent credentials seeking to join a group practice/employment in Dallas/Fort Worth or suburbs. Green card holders. Contact (915) 544-9913; Beeper (915) 663-9097.

FOR SALE OR LEASE

Practices For Sale

Lucrative, Active Family Medicine/Pediatric Practice—Well-established, very active family medicine/pediatric practice for sale in South Coastal Texas. Gross over $550,000. Prefer to phase in newcomer over 6-12 months period. Call (361) 575-8514.

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PRACTICE FOR SALE: Solo Internal Medicine practice in suburban Corpus Christi, adjacent to a 69-bed hospital, 1 in 4 week call. Treadmill system, Holter system, and sigmoidoscope are included in the sale. Income is $250,000+ annually. Sale price: $50,000. Call (361) 882-8146 home, (361) 387-6244 office, or (361) 885-1379 beeper. Available now.

Minor Emergency Clinic for Friday, Saturday, Sunday lease. Over 4,000 active patients on busy North IH-35. Fax (956) 727-2435 or call Ceci, (956) 727-0444 after 4:30 p.m.

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Educational Opportunities

MINIMALLY INVASIVE SURGERY OVERVIEW FOR THE PRIMARY CARE PHYSICIAN

JUNE 26, 1999
DALLAS, TEXAS

Course Director: Daniel B. Jones, M.D.

The University of Texas Southwestern Medical Center at Dallas, the accredited sponsor, is jointly sponsoring this activity with Zale Lipshy University Hospital in conjunction with with The Southwestern Center for Minimally Invasive Surgery

PLACE:
Excellence in Education Foundation Auditorium Harold C. Simmons Biomedical Research Building
2nd Floor UT Southwestern Medical Center at Dallas

DESCRIPTION:
This Symposium will present to the primary care physician an update on the latest surgical techniques and emerging technology available in Minimally Invasive Surgery.
• Lectures • Hands-on Workshops
• Live Tele-Surgery • Panel Discussion
CME credit offered

FEE:
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CONTACT:
Continuing Education; UT Southwestern Medical Center at Dallas / 5323 Harry Hines Boulevard / Dallas, TX 75235-9059
Phone: 214/648-2166, 1/800/688-8678, Fax: 214/648-2317
http://www.swmed.edu/home_pages/cme/cemain.html
www.swmed.edu/cmis

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Emergency Medicine	July 22-24
Advanced Emergency Medicine	July 9-10 November 5-6
Endovaginal	August 20-21
Echocardiography	July 12-19
OB/GYN (3 Day)	August 12-14
Vascular	June 21-25
Breast Ultrasound	June 19
Abdominal (5 Day)	July 26-30
OB/GYN (5 Day)	August 2-6
Prostate	August 7
Ultrasound for Surgeons	August 27-29

Courses listed above are held in Houston, TX. Contract courses can be brought to your location; minimum enrollment required. Call (800) 239-1361 for more information and/or a free catalog.

Advanced Health Education Center
8502 Tybor Street, Houston, TX 77074

Approved for AMA Category I credit

www.aheconline.com

Santa Fe Colloquium on Cardiovascular Therapy: Can Coronary Artery Disease Be Stabilized or Reversed? What About Primary Prevention? Oct. 7-9, 1999, Eldorado Hotel, Santa Fe, New Mexico. Sponsored by American College of Cardiology. CME credits: 17 category 1 AMA. For information, contact: Registration Secretary, Extramural Programs Dept., American College of Cardiology, 9111 Old Georgetown Rd., Bethesda, MD 20814-1699; (800) 253-4636, ext. 695 (outside the U.S. and Canada, (301) 897-5400, ext. 695); fax (301) 897-9745.

Southwestern Center for Minimally Invasive Surgery: Urology, June 4-5. Sponsored by UT Southwestern Medical Center at Dallas. Excellence in Education Foundation Auditorium, Simmons Biomedical Research Building. Course Director: Margaret Pearle, MD, AMA credit offered. Contact: Leah Cannon, program coordinator (214) 648-3792.

Science of Family Medicine, June 9-13. Sponsored by UT Southwestern Medical Center at Dallas. Excellence in Education Foundation Auditorium, Simmons Biomedical Research Building. Course director: Claire McCluggage, MD, and Joe Ventimiglia, MD. AMA and AAFP credit offered. Contact: Lisa Dunlevy, program coordinator, (214) 648-9532.

Update in Pain Management, June 19. Sponsored by UT Southwestern Medical Center at Dallas. Excellence in Education Foundation Auditorium, Simmons Biomedical Research Building. Course director: Noor Gajraj, MD. AMA and AAFP credit offered. Contact: Stacey Novotny, program coordinator, (214) 648-3784.

The Third Annual Enhancing Your Clinic Practice Using New Technology, June 19 (pre-conference June 18). Sponsored by UT Southwestern Medical Center at Dallas. McDermott Plaza, D1.602. Course director: Ron Peshock, MD. CME credit offered. Contact: Kraig Steubing, program coordinator, (214) 648-9350.

Physicians at the Crossroads, June 25. Sponsored by the Alliance for Medical Management Education and UT Southwestern Medical Center at Dallas, Excellence in Education Foundation Auditorium, Simmons Biomedical Research Building. Course director: Willis Maddrey, MD. AMA credit offered. Contact: Continuing Education, (214) 648-2166.

Zale Lipshy University Hospital Minimally Invasive Surgery Overview for the Primary Care Physician, June 26. Sponsored by the Southwestern Center for Minimally Invasive Surgery and UT Southwestern Medical Center at Dallas, Excellence in Education Foundation Auditorium, Simmons Biomedical Research Building. Course director: Daniel Jones, MD. CME credit offered. Contact: Continuing Education, (214) 648-2166.

Southwestern Center for Minimally Invasive Surgery: Laparoscopic Management of Common Bile Duct Stones, July 23-24. Sponsored by Department of Surgery and SCMIS. Located in the Simmons Biomedical Research Building, Excellence in Education Foundation Auditorium. CME credit offered. Course director: Robert V. Rege, MD. Contact Leah Cannon, (214) 648-3792.

Annual Breast Care Advances and Bioskills Training Conference, August 21. Sponsored by UT Southwestern Medical Center at Dallas Department of Surgery, Excellence in Education Foundation Auditorium, Simmons Biomedical Research Building. Course director: R. Rohrich, MD, G. Peters, MD, M. Leitch, MD, and E. Frenkel, MD. CME credit offered. Contact: Continuing Education, (214) 648-2166.

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BackTalk

Question

How do you address sensitive issues with teenagers, such as pregnancy, smoking, and alcohol use?

"Don't preach, don't preach, don't preach! I don't tell them not to do those things. I simply help them take responsibility, not blame, for their choices."

Melvyn L. Smith, MD, 57
family practice, Sugar Land

"I start by discussing noncontroversial issues, such as questions about family and school. I proceed by asking what is going on with classmates and friends — if any of them have become pregnant or have potential for problems with the police. From there, I explore the patient's opinions about tobacco, alcohol, drugs, and sex."

Jesus E. Fajardo, MD, 56
pediatrics, Temple

"I'm 33 and a little closer to that age group, so I try to make them feel like there's not a lot of discrepancy in our ages — that I'm 'hip' and understanding of their problems. Hopefully, I'm opening up a door so they feel that we have mutual interests, and they'll open up about their feelings and problems."

C. Mark Chassay, MD, 33
family practice, Austin

"I address these issues sensitively, without presumption of being a know-it-all, delighting in the teens' beginning formulations of important developmental issues, and sometimes being like Detective Columbo, with his beagle and sandwich in the same car."

Mitch Young, MD, 47
child and adolescent psychiatry, Houston

"I prefer to speak with them without parents in the room, if possible, if there is agreement from them without hesitation. If the parents want to stay, that's fine, too. I follow up by meeting with everyone. I try to be sincere and show that I care for their best interests."

Lan-Anh Ngo, MD, 34
family practice, San Antonio

"There are two phases of information-gathering from teenagers that I do. I use the AMA's Guidelines for Adolescent Preventive Services forms as a screening tool. In addition, I go over these questions with patients so I can counsel them and provide them with health and safety information in return for the information they give me. I ask them these questions without parents in the room and preserve their confidentiality unless it would result in harm to the patient. I address these issues in a confidential, nonthreatening, health-preventive way."

Amy Middleman, MD, 34
pediatrics-adolescent health, Houston

Back Talk is a nonscientific sampling of Texas physicians' opinions on a topic of interest. Physicians are polled by telephone, fax, or e-mail. We welcome suggestions for future topics. Send them to *Texas Medicine*, Back Talk, 401 W 15th St, Austin, TX 78701; fax them to (512) 370-1632; or e-mail them to m_mcever@texmed.org.

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The Big Picture

A giant swallowtail butterfly visits a blue mist flower, by Clyde M. Caperton, MD, Bryan
If you would like to submit a photograph for The Big Picture, please send it to Laura J. Albrecht, Photo Editor, *Texas Medicine*, 401 W 15th St, Austin, TX 78701.

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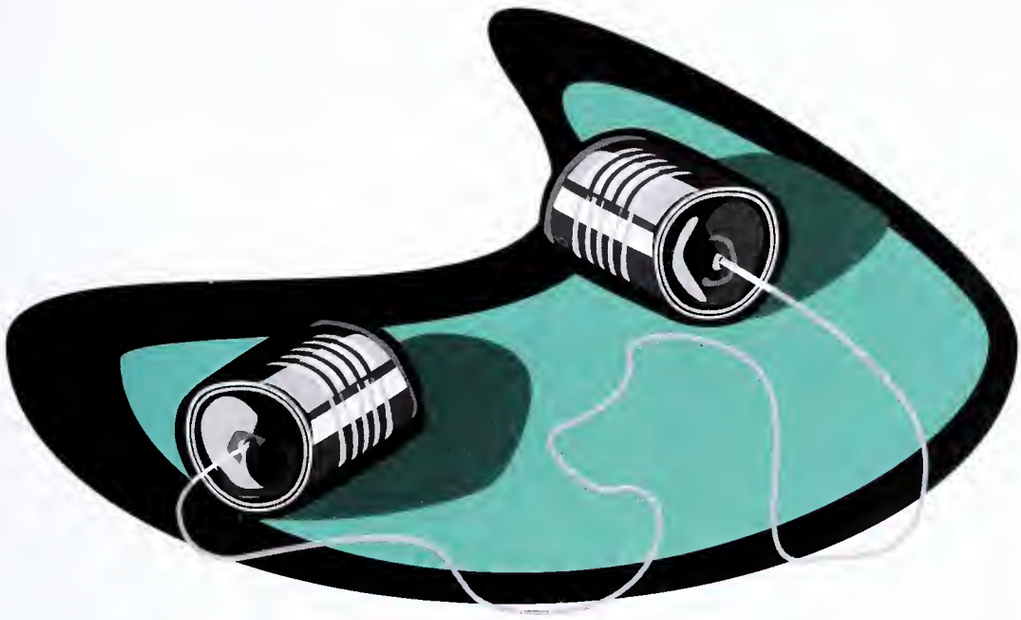

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Editor's Note

There's an old expression, put to music several years ago by The Fabulous Thunderbirds, that one's too many and a hundred's not enough. Though probably said about a glass of whiskey, an argument could be made that the adage applies to the supply of physicians in Texas. Having the right kinds of physicians in the right places and in the right numbers is the key to making sure our state's physician workforce addresses the needs of patients in whatever part of Texas they live.

In this month's cover story, "Shortage Amid Surplus," Associate Editor Monica Maldonado ventures into the complex world of the Texas physician workforce and explores what is being done to ensure an adequate supply of physicians. The number of medical schools, class sizes, and the funding of graduate medical education are only a few pieces of the puzzle.

Also food for thought in this issue is Senior Editor Teri Moran's look at the growing trend toward hospitalists and whether health plans should be able to make their use mandatory. Like any health care issue these days, there are good and bad points on each side. In "Just Don't Make Me," Teri carefully examines the pros and cons. Much of what she finds may surprise you.

And, for those who didn't attend TexMed '99 in May (shame on you!), Associate Editor Johanna Franke gives a complete wrap-up of all the activities in the "Rounds" section. By the way, it's not too early to be thinking about TexMed 2000 in San Antonio next May.

Larry BeSaw
Managing Editor

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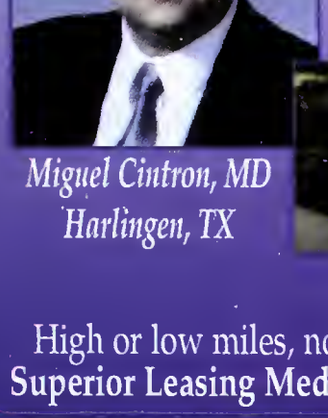

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Letters

Encryption not a good idea

You set a dangerous precedent when you quoted Dr Suarez as saying it's imperative that all patient communications be encrypted ("Cyberspace Medicine," May 1999 *Texas Medicine,* pp 36–42). This statement implies liability if a doctor does not send encrypted e-mail.

At this time, I do not send encrypted patient e-mail for several reasons. To begin with, encryption is no longer secure. For example, the Pegasus scheme Dr Suarez recommends uses a PGP (pretty good privacy) signature. At the Dallas Virus Response Team, we have studied computer viruses that steal a user's PGP from his desktop and e-mail it back to the virus sender. These viruses easily escape detection by commercial virus scanners.

Also, encryption creates too much paperwork. It is complicated to maintain a system of personal identification numbers (PINs) for patients, especially because these PINs have to be sent via surface mail. Unfortunately, Dr Suarez's idea of using a patient's Social Security number is not very secure.

Instead of encryption, the best protection for doctors and patients is to have a well-written disclaimer attached to each e-mail. This not only protects the doctor from liability, but also informs the patient about the inherent risks of e-mail. For help writing the disclaimer or for anyone who wants to use e-mail to communicate with patients, I recommend first reading the "Guidelines for the Clinical Use of Electronic Mail with Patients" (*J Am Med Inform Assoc.* 1998 Jan–Feb;5:104–111).

Cyrus Peikari, MD
Member, Dallas Virus Response Team
Member, TMA Virtual Advisory Committee
6242 Walnut Hill Lane
Dallas, TX 75230

Dr Suarez responds

I agree with Dr Peikari's comments regarding encryption of messages. It is certainly not 100% secure and it does require irritating paperwork. However, I must persist in my respectful disagreement regarding the necessity of encryption. One of the basic tenets of the patient-physician relationship is the presumption of privacy and confidentiality. Our patients deserve the protection of their privacy rights, particularly in this "cyberspace" era. Survey after survey discovers that the American public is most concerned with medical privacy as we all delve into the wonders of the Internet.

At TexMed '99 in May, we spent Friday afternoon discussing the subtleties and complexities of patient privacy rights. Again, the presumption always is in the favor of the patient's confidentiality.

While patients can be told that Internet mail is an insecure transmission, they may not truly realize what those words mean until their privacy has been violated by the inadvertent delivery of a sensitive medical document to 15,000 local residents in their town.

I am certain that as Internet law develops, we will have case after case of inadvertent breakdowns in patient confidentiality. I am equally certain that the physician who encrypts his messages containing specific medical information, no matter how benign, will show intent to protect confidentiality and will be shielded from liability.

Yes, setting up e-mail encryption protocols is time-consuming and not absolutely 100% secure (as if anything we do in medicine is 100% effective). We, as physicians caring for human beings, must endeavor to always protect this sacred relationship with our patients. The physician who doesn't at least try will eventually be speaking to lawyers in expensive three-piece suits explaining why he didn't.

Philip Suarez, MD
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Member, TMA Council on Communication
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Study findings questioned

In reference to the article by Wong et al in the May issue of *Texas Medicine* (1), the authors wrongly concluded the case of right ventricular infarction superimposed on pulmonary hypertension due to chronic thromboembolic pulmonary hypertension (CTPH) as a case of acute pulmonary embolism.

Clinical examination showing a stable blood pressure, no tachycardia, and no tachypnea argues against acute pulmonary embolism. Moreover, pH of 7.41 on arterial blood gas indicates a compensated process and not an acute event. Although it is not a case of left ventricular infarction, in the setting of pulmonary hypertension, right ventricular infarction can happen. Right chest leads would be an appropriate choice.

CTPH is one of a few treatable causes of pulmonary hypertension, as surgical thromboendarterectomy is now performed in specialized centers worldwide. Diagnosis depends on a ventilation-perfusion scan showing at least one segmental or larger perfusion lung scan defect, mean resting pulmonary artery pressure >25 mm Hg with a mean pulmonary artery wedge pressure <12 mm Hg, and an angiographic pattern of webs, bands, intimal irregularities, rounded termination of pulmonary branches, etc (2).

A hypercoagulable state can be found in up to 30% in some recent series (2) and should be evaluated.

Also, the choice of an inferior vena caval (IVC) filter along with Coumadin is highly debatable. The indication of an IVC filter is in patients for whom anticoagulation is contraindicated or ineffective. Some people consider an IVC filter as the first option in the elderly because of a high risk of bleeding and also in patients with malignancy. A study comparing the IVC filter with anticoagulation in malignancy supports an approach of routine anticoagulation with selective filter placement (3).

Khusro Rashid, MD
Community General Hospital
230 W Miller St
Dilley, TX 78017

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Dr Wong responds

We appreciate the comments of Dr Rashid. The early diagnosis of acute pulmonary embolism in our patient was based on the typical appearance of the abnormal ventilation-perfusion scan, an electrocardiographic appearance of right ventricular dilation, grossly depressed right ventricular function, and a mild-to-moderate elevation of pulmonary pressure. Chronic thromboembolic pulmonary hypertension is possible but unlikely, in view of the present Doppler-derived pulmonary pressure, which was not very high.

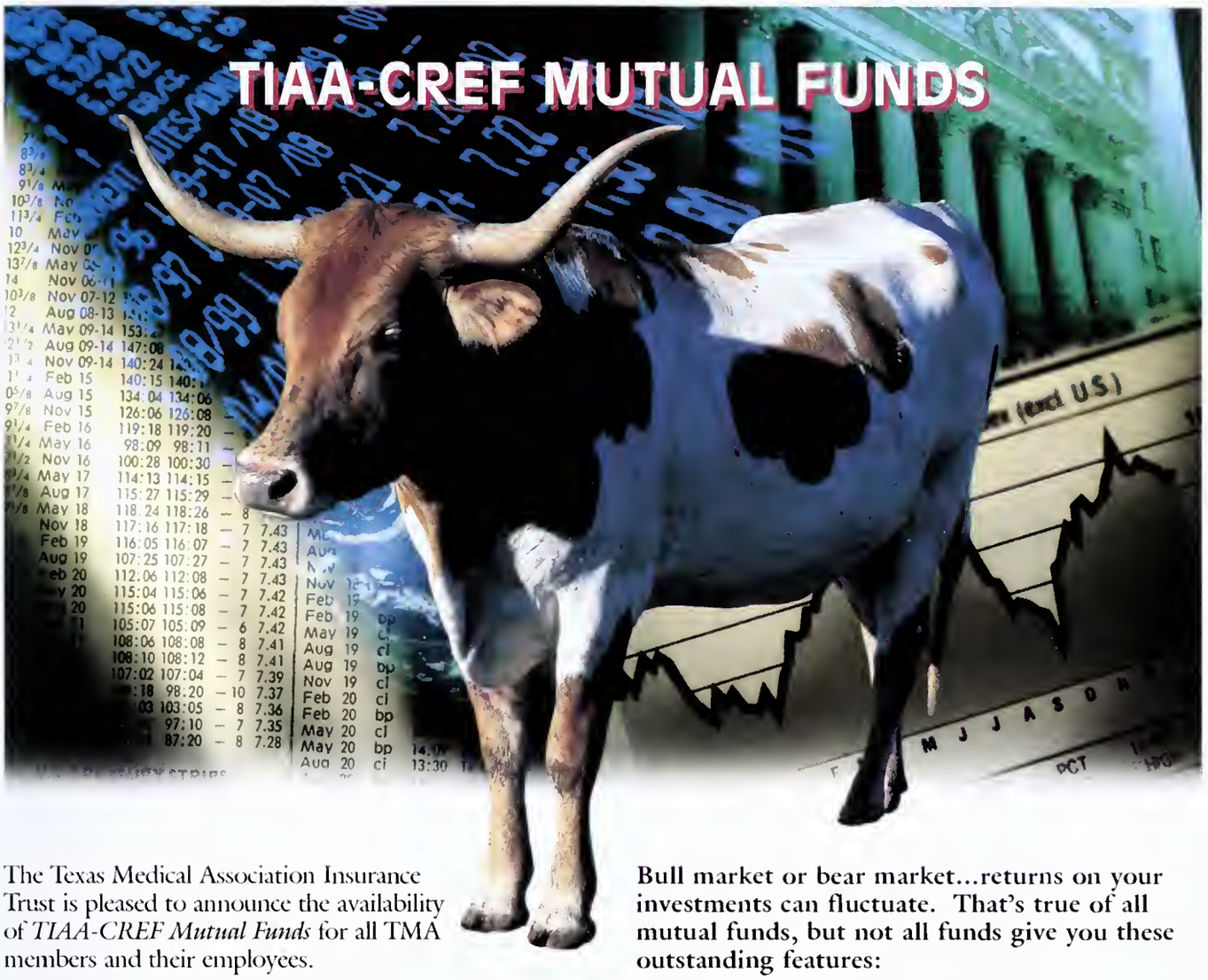
The use of inferior vena caval (IVC) filters is controversial in patients with pulmonary embolism. In general, prophylaxis with IVC filters is indicated for patients with initial pulmonary embolism who are thought to be at an increased cardiopulmonary risk, such as elderly patients with a poor cardiopulmonary reserve. If this patient did suffer from chronic thromboembolic pulmonary hypertension as suggested by Dr Rashid, short of the surgical procedure described by Dr Rashid, which can be performed only in specialized centers, IVC filter implantation along with long-term anticoagulation also is considered an acceptable treatment.

Thrombolytic therapy has been used with success in patients with acute pulmonary embolism with right ventricular dysfunction and normal systemic arterial pressures and may improve morbidity and mortality, but the clinical experience has not been extensive.

One should note that the intermediate term prognosis after an episode of venous thromboembolism and pulmonary embolism is not good, with a 1-month mortality rate of 28% and a 1-year mortality rate of 37%. The fact that our patient has been well and alive after being followed for more than 9 months on an outpatient basis without any further episodes of clinical recurrence indicated that our management was very appropriate.

Christopher Wong, MD
North Houston Cardiovascular Associates
3500 W Davis, Ste 220
Conroe, TX 77304

Announcing A New Way For TMA Members To *Take Wall Street By The Horns*



The Texas Medical Association Insurance Trust is pleased to announce the availability of *TIAA-CREF Mutual Funds* for all TMA members and their employees.

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For more complete information about the *TIAA-CREF Mutual Funds*, including charges and expenses, please call 1 877 276-9429 for a prospectus. Please read the prospectus carefully before you invest or send money.

NOTE: Neither TMAIT nor TMA receive any commissions, income or fees for the sponsorship of the *TIAA-CREF Mutual Funds*. TMAIT is, however, reimbursed for certain administrative expenses associated with the sponsorship.

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People

Newsmakers

Fort Worth psychiatrist **Virgil M. Cox, Jr, MD,** received the Herman Staples Distinguished Service Award from the American Society of Adolescent Psychiatry.

Plano pediatrician **Allan R. DeVilleneuve, MD,** received the 1999 Savvy Award, which recognizes outstanding Dallas-area volunteers, for cofounding the Plano Children's Medical Clinic.

Glennon R. Einspanier, DO, Abilene, was elected chair-elect of the General Surgery Division of the American College of Osteopathic Surgeons.

Fort Worth surgical oncologist **John W. Freese, MD,** received the Dr. Truman C. Terrell Award from All Saints Health Foundation.

Stanford M. Goldman, MD, Houston, is serving as secretary-treasurer of the American Society of Radiology.

The 1999–2000 Texas Ophthalmological Association officers include **M. Bowes Hamill, MD,** Houston, president; **George C. Thorne, Jr, MD,** Austin, president-elect; **Keith D. Fisher, MD,** Fort Worth, secretary; and **Jon T. Schreiber, MD,** Tyler, treasurer.

Houston internist **Carlos R. Hamilton, Jr, MD,** received the Silver Buffalo Award from the Boy Scouts of America.

John H. Harris, Jr, MD, Houston, received the Gold Medal from the American Society of Emergency Radiology.

Dallas chemical pathologist **Ishwarlal Jialal, MD,** received the International Hermes Vitamin Award 1998 for unpublished research on vitamin E titled "The Effect of Alpha-Tocopherol Supplementation on LDL Modification and Monocyte Function in Type 2 Diabetic Patients With and Without Macrovascular Complications."

Grapevine psychiatrist **Gary L. Malone, MD,** was appointed medical director of All Saints Health System's behavioral health sciences.

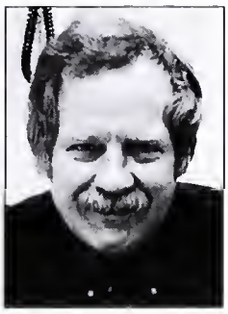
Houston internist **John Mendelsohn, MD,** received the Joseph H. Burchenal AACR Clinical Research Award from the American Association for Cancer Research for his "pioneering work" in elucidating the roles of growth factors and receptors in cell regulation and proliferation.

The 1999–2000 Texas College of Emergency Physicians officers include **David Pillow, MD,** Dallas, president; **Robert Greenberg, MD,** Temple, president-elect; and **Jerry Gray, MD,** Sherman, secretary.

Stanford M. Goldman, MD

Ishwarlal Jialal, MD

John Mendelsohn, MD



John K. Wood, MD

The 1999–2000 Tarrant County Medical Society officers include plastic surgeon **Larry E. Reaves, MD,** president; allergist **Bobby Q. Lanier, MD,** president-elect; general surgeon **James L. Norman,** vice president; family practitioner **James A. Murphy, Jr, MD,** secretary; and orthopedic surgeon **Robert W. Hunnicutt, MD,** treasurer.

The 1999–2000 Hispanic American Medical Association of Houston officers include orthopedic surgeon **Jose E. Rodriguez, MD,** president; cardiothoracic surgeon **Javier A. Lafuente, MD,** president-elect; urological surgeon **Demetrio**

Please let *Texas Medicine* know about your honors and achievements. Criteria for inclusion in the Newsmakers section are TMA membership; election or appointment to an office of, or honors from, a national or state organization; or, space permitting, recognition at the local level. Items for the Newsmakers section are published at the discretion of the managing editor. Submit items for consideration, with photos if possible, to Johanna Franke, People, *Texas Medicine*, 401 W 15th St, Austin, TX 78701; fax (512) 370-1632; e-mail johanna_f@texmed.org.

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People

Tagaropulos, MD, secretary; and physical medicine and rehabilitation specialist **Remberto Rangel, MD,** treasurer.

Family practitioner **John K. Wood, MD,** was chosen chair of the Board of Directors for Inova Health, Inc, in Dallas. Dr Wood succeeds family practitioner **John L. Kelley, MD,** who retired in May.

Deaths

James William Caldwell, MD, 74; McAllen; University of Tennessee College of Medicine-Memphis, 1950; died April 15, 1999.

Dorothy Annette Cato, MD, 83; Houston; The University of Texas Medical Branch at Galveston, 1946; died May 6, 1999.

Bryan William Forister, MD, 74; Carefree, Ariz; Johns Hopkins University School of Medicine, 1954; died April 19, 1999.

Stanley Donald Greenberg, MD, 68; Houston; Baylor College of Medicine, 1954; died May 6, 1999.

Edward Clayton Kahler, MD, 74; Garland; The University of Texas Southwestern Medical School at Dallas, 1953; died April 30, 1999.

Louis Kenneth Mantell, MD, 90; San Antonio; Northwestern University Medical School, 1935; died April 20, 1999.

Karl Franklin Roehrig, MD, 77; Dallas; University of Colorado School of Medicine, 1952; died May 3, 1999.

Arnold Ira Walder, MD, 64; San Antonio; State University of New York Health Science Center at Brooklyn College of Medicine, 1958; died April 22, 1999.

Going The Extra Mile For The Referring Physician: Cook Children's Talks With Dr. W. Paul Bowman.

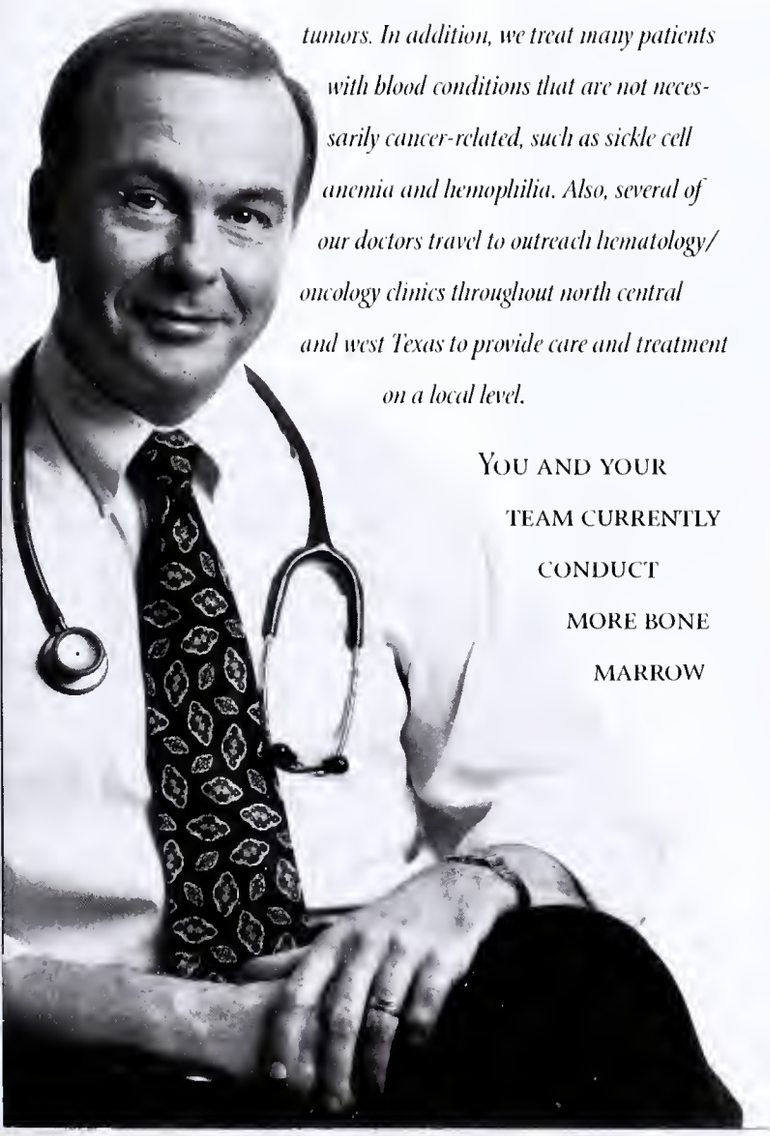
DR. W. PAUL BOWMAN — MEDICAL DIRECTOR OF HEMATOLOGY/ONCOLOGY

DR. BOWMAN, WHAT TRENDS ARE YOU SEEING IN THE FIELD OF PEDIATRIC HEMATOLOGY/ONCOLOGY?

Significant strides have been made in the treatment of childhood cancer. Today, more than 70 percent of the children newly diagnosed with cancer can be expected to enjoy a relatively long life and possibly even see a cure for their disease.

WHAT TYPES OF DIAGNOSES ARE YOU ABLE TO TREAT GIVEN THE SCOPE OF SERVICES, CLINICAL EXPERTISE AND RESOURCES AVAILABLE AT COOK CHILDREN'S?

We're able to provide care for patients who are afflicted with a wide range of illnesses: leukemia, malignant lymphoma, brain tumors and solid tumors. In addition, we treat many patients with blood conditions that are not necessarily cancer-related, such as sickle cell anemia and hemophilia. Also, several of our doctors travel to outreach hematology/oncology clinics throughout north central and west Texas to provide care and treatment on a local level.



YOU AND YOUR TEAM CURRENTLY CONDUCT MORE BONE MARROW TRANSPLANTS THAN ANY OTHER CHILDREN'S HOSPITAL IN TEXAS AND SURROUNDING STATES. WHAT DO YOU THINK SETS YOU APART FROM OTHER CHILDREN'S HOSPITALS?

In 1986, we opened the first pediatric bone marrow transplant program in the region and have had very good success. Our center is approved by the National Marrow Donor Program as a registry, collection, and transplant center. We perform both allogeneic and antologous transplants, as well as utilize unrelated donors for patients lacking a family match.

DR. BOWMAN, WHAT IS IT THAT A REFERRING PHYSICIAN WANTS MOST TO GET OUT OF HIS OR HER RELATIONSHIP WITH A SPECIALIST?

He or she wants to know that the patients and their families will be provided with the best care available; that they will have a positive experience, and have confidence in the treatment team. He or she wants to be kept apprised of the patient's status, stay involved in the follow-up care, and provide support to the family.

COOK CHILDREN'S IS AN INDEPENDENT COMMUNITY-BASED HEALTH CARE SYSTEM, COMBINING THE BEST IN PATIENT CARE WITH RESEARCH. HOW DOES THIS BENEFIT THE PATIENT?

We provide patients with the best of both worlds – treatment and research. We focus primarily on the clinical aspects of the patient's care and also participate in ongoing research programs. We believe we are in the best position to offer greater continuity of care, since taking care of the patient is our number one concern.

Cook Children's Medical Center is located in Fort Worth, Texas. For more information about Dr. Bowman and our other pediatric oncologists – Gretchen Eames, David Friedman, Timothy Griffin, Jeffrey Murray, Joann Sanders, Ami Slah, Juan Bernini in Midland/Odessa and Benjamin Carcamo in El Paso – call 1-800-COOK517.

CookChildren's
Medical Center

Texas Medicine Rounds

By Johanna Franke

TexMed '99

Delegates oppose mandatory hospitalists, support tobacco money for health care

Jim Lincoln

Alan C. Baum, MD, of Houston, and Pam Hendricks, of Temple, were sworn in as presidents of the Texas Medical Association and Texas Medical Association Alliance during TexMed '99. In his installation address, Dr Baum urged TMA members to ignore the "conventional wisdom" that medicine's best days are in the past and that physicians are powerless to maintain their ability to fight for the best interests of their patients. "Whoever is writing conventional wisdom these days hasn't been reading the history of the Texas Medical Association," he said. "They can't see what we have seen. They don't know about yesterday's victories and about our real and honest hopes for tomorrow. They don't know about our secret weapons — our patients, our professionalism, our pride." TMA has been fighting for the rights of patients and physicians for almost 150 years, he said, "and we plan to be here a good 150 more."

Expressing the Texas Medical Association's opposition to the mandatory use of hospitalists and reiterating its support for using tobacco lawsuit settlement money for health care were among the actions taken by the TMA House of Delegates during TexMed '99: Educational Showcase & Expo in Dallas in May.

More than 50 reports and resolutions dealing with patient protection and patient rights issues and other socioeconomic, public health, medical education, scientific affairs, and association organizational matters were acted upon by the House.

Delegates went on record against the mandatory use of hospitalists proposed by some health insurance plans, institutions, or other entities (see "Just Don't Make Me," pp 32–36.) House members voted for the voluntary use of hospitalists as deemed appropriate by physician-led policymaking bodies advising health plans, institutions, and other entities.

The action was taken after some health plans announced their intent to institute mandatory hospitalist programs in Harris and Travis counties.

On the tobacco money matter, the

House voted for allocating funds gained from settling the state's lawsuit against the tobacco industry to assist in diagnosing and treating people harmed by tobacco or its by-products. It also voted to support the hospital districts that intervened in the lawsuit to have settlement funds specifically allocated to health care. Delegates urged counties that do not have hospital districts to use the settlement money they receive for health care and not for general purposes such as roads and bridges.

Other major House actions included adoption of resolutions that TMA:

- Seek legislation requiring the Texas State Board of Medical Examiners (TSBME) and other health care entities to report only final disciplinary actions, and seek legislation prohibiting health care entities from requiring physicians to report pending investigations.
- Oppose weakening by federal preemption of state laws protecting medical privacy; oppose establishment of a new corporate right to own, collect, or use medical databases; and oppose funding or implementation of the National Patient Identifier under the Health Insurance Portability and Accountability Act.
- Oppose federal government attempts to establish boards to oversee state licensure bodies and to impose federal competency checks through on-site inspection, chart reviews, or periodic written examination.
- Encourage the Texas Higher Education Coordinating Board (THECB) to consider the physician supply/requirements projections in the 1998–1999 TMA Workforce Study in identifying the state's graduate medical education (GME) needs, and to take them into account in determining funding priorities for the GME program (see "Shortage Amid Surplus," pp 38–45). Delegates also reaffirmed existing TMA policy supporting the elimination of the current legislative appropriations rider language requiring a minimum class size for each Texas medical school.
- Communicate to the THECB and the 76th Texas Legislature TMA's support of legislation establishing the Coastal Bend Health Education Center (CBHEC). A proposal that TMA work with Sen Carlos F. Truan (D-Corpus Christi) and Texas A&M University Health Science Center in the 2001 legislative session to develop and pass legislation establishing the medical student aspect of the CBHEC was referred to the Council on Medical Education for a report back to the House in May 2000.
- Target actions to deal with inappropriate claims-bundling and downcoding practices, including regular meetings with payers, to identify specific claims-processing practices and policies that contribute to the problem, and participate in appropriate liaison and joint action with the American Medical Association, specialty societies, and other organizations.
- Support physician-formulated guidelines for treating spine injuries based on objective science, quality of care, and outcomes studies; work with the Texas Workers' Compensation Commission (TWCC) to ensure that workgroups include physicians with appropriate expertise and qualifications; and work with TWCC to identify such candidates for the TWCC Spine Treatment Guideline Workgroup.
- Approve changing the name of TMA's Resident Physician Section to the Resident and Fellow Section. The

Something to consider

A resolution from the Smith County Medical Society recommending the terms "patient" and "physician" be used instead of "provider" and "covered lives" in Texas Medical Association resolutions and communications with TMA members, the public, and the news media was adopted by the House of Delegates during TexMed '99.

During the consideration of the resolution, R.L. Campbell, MD, of Corsicana, made a point of personal privilege address to the House in which he read "Eulogy of the Doctor" by Robert Louis Stevenson:

> **There are men and classes of men that stand above the common herd. The soldier, the sailor, the shepherd, not infrequently; the artist rarely, rarer still the clergyman, the physician almost as a rule. He is the flower of our civilization and when that stage of man is done with, only to be marveled at in history, he will be thought to have shared but little in the defects of the period and to have most notably exhibited the virtues of the race. Generosity he has, such as is possible, only to those who practice an art and never to those who drive a trade. Discretion, tested by a hundred secrets. Tact, tried in a thousand embarrassments, and what are more important, Herculean cheerfulness and courage. So it is that he brings air and cheer into the sick room and often enough, though not so often as he desires, brings healing.**

Dr Campbell urged House members to remember who they are. "You are a physician or a doctor; you are not a provider," he said. "You are called to serve because you have a gift. And I'm here to tell you why you should be proud, not arrogant, but proud; why you should be humbled but never meek. You are far above those who would control you or tell you what's ethical, such as politicians, bureaucrats, and insurance clerks. Don't give up, ever. Don't ever accept defeat. Compromise only when it's absolutely necessary as a temporary maneuver, but always keep victory in mind. Don't give up on medicine."

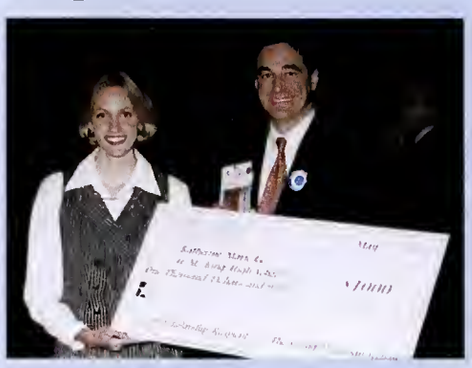
***Texas Medicine* and the TMA Division of Communication adhere to a policy to avoid using the terms "provider" and "covered lives" whenever possible.**

TexMed '99 Images

TMA Past President John P. Howe III, MD, far left, and TMA President-Elect J. James Rohack, MD, far right, present scholarships to Damien Luviano, of Houston, Rodolfo Herrera, of San Antonio, and Eugene Ramirez, of El Paso, on behalf of the TMA Minority Scholarship Program at TexMed '99. During the program's inaugural year, 3 of the 70 applicants, all of whom were required to be accepted to their respective medical schools before applying for the program's scholarships, were selected to receive $5,000 each. The program, supported solely by TMA member donations, was approved by the TMA House of Delegates in April 1998.

TMA's Student Loan Program, which administers the minority scholarships, and the TMA Board of Trustees recognized several of the loan program's interviewing trustees on the House floor at TexMed '99 for their dedication. These TMA loan program trustees and their years of service are Paul J. Cunningham, MD, Galveston, 25 years; S. Perry Post, MD, San Antonio, 19 years; Byron L. Howard, MD, Dallas, 17 years; Leonard E. Lawrence, MD, San Antonio, 17 years; John McNew, MD, Bryan, 17 years; Betty P. Stephenson, MD, Sugar Land, 17 years; James F. Kirk, MD, Lubbock, 16 years; and Elgin W. Ware, Jr, MD, Dallas, 15 years.

Outgoing Medical Student Section (MSS) Chair Stanley Wang, a student at The University of Texas Southwestern Medical School in Dallas, left, presents the 1999 MSS Chapter of the Year Award to the students of the Texas College of Osteopathic Medicine (TCOM) at the University of North Texas Health Science Center in Fort Worth. TCOM student Jose Villarreal, right, accepted the award on behalf of the chapter, which boasted a 100% TMA membership. The TMA-MSS also presented the Student of the Year Award to UT-Southwestern student Vladimir Zuzukin and the C. Frank Webber Award to Lubbock pediatric endocrinologist Surendra K. Varma, MD.



Outgoing Young Physician Section Chair J. Timothy Parker, MD, of Denison, presents Katherine Marie Cox, a student at H.M. King High School in Kingsville, a $1,000 check from the section's Rural Scholarship Fund at TexMed '99. Rural scholarship recipients not pictured are James Cantu, a Floresville High School student, who received $750, and Amanda Hershman, a Pleasanton High School student, who received $500.

Outgoing Young Physician Section Chair J. Timothy Parker, MD, of Denison, right, presents the 1999 Young at Heart Award to former TMA President Phil H. Berry, Jr, MD, of Dallas, at TexMed '99.

Three outstanding Texas educators received the 1999 Excellence in Science Teaching Award at TexMed '99. From left are Cynthia Radle, Travis Middle School, Temple; John Burnside, MD, chair of TMA's Council on Scientific Affairs, who presented the awards; John S. Terry, Denison High School, Denison; and Edwinna B. Bernat, S.C. Red Science and Math Elementary Magnet School, Houston.

Jim Lincoln

AMA House of Delegates approved an AMA Resident Physician Section resolution to rename its section the Resident and Fellow Section during AMA's 1998 annual meeting.

The Texas Delegation to the AMA submitted six resolutions to the AMA House of Delegates for consideration at its annual meeting in June. One directed TMA to support efforts to address federal antitrust reforms and petition the AMA to continue assisting physicians and their groups in contract negotiations and the advancement of fair standards for physician contracts. The other five focused on creation of a Council on Membership, health care equity in Medicare reform, a strategy for individual ownership of health insurance, medical records privacy, and Medicare support for residency training.

The House rejected a recommendation that TMA President Alan C. Baum, MD, appoint an ad hoc committee to study the restructuring of the association.

Several items were referred to the Board of Trustees for further study and report back to the House including:

- Developing a peer review process to identify expert physician witnesses who engage in fraud or deception and explore the possibility of working with TSBME to devise a category of temporary state licensure to give testimony intrastate.
- Reaffirming the value of the family and good parenting; encouraging all parents to seek support and guidance; and encouraging attorneys, judges, and legislators to affirm the value of good parenting.

In addition, the House referred to the Council on Socioeconomics a resolution regarding claims recoupment. It recommends TMA seek assistance from the Texas Department of Insurance and the Texas attorney general's office to stop insurance companies and payers from recouping past paid claims when the claims were filed in good faith, and when the disputes resulted from insurance company mistakes. The council was asked to report back to the House at its interim session in November. ★

Nixon dedicates Distinguished Service Award to his teachers

When Sam A. Nixon, MD, wins a big award, he knows whom to thank — his teachers.

Dr Nixon gratefully acknowledged his instructors when he received the Texas Medical Association's Distinguished Service Award during a House of Delegates meeting at TexMed '99 in Dallas.

"An old saying in education is, 'If the learner hasn't learned, then the teacher hasn't taught,'" Dr Nixon said. "I trust that this award demonstrates that teachers can do wonderful things with the raw materials presented to them, and I thank each and every one of mine, and I accept it on their behalf."

Jim Lincoln

TMA Past President Sam A. Nixon, MD, accepts TMA's Distinguished Service Award and praises his lifetime of teachers before the House of Delegates at TexMed '99.

Dr Nixon displayed many of his teachers' names on a screen behind him and counted his parents and his wife, Elizabeth, among his greatest educators as he addressed House members, who gave him a standing ovation.

"I am grateful forever for the instructions given by the House of Delegates over the last 45 years," Dr Nixon said. "You have set my course of service for this profession."

A former TMA president, Dr Nixon has served as chair of TMA's Council on Public Health and as president of both the Texas Academy of Family Physicians and the American Academy of Family Physicians (AAFP). He serves on the Board of Curators of the Archives of the AAFP Foundation and has been chair of the State Rural Medical Education Board since 1975.

After being appointed to the American Medical Association Council on Environmental, Occupational, and Public Health and the Council on Continuing Physician Education, Dr Nixon was elected to the AMA Council on Medical Education and served as its chair in 1991 and 1992. He has been an AMA delegate since 1977 and has served as an AMA representative to the Accreditation Council for Continuing Medical Education.

Dr Nixon's devoted service to medical education began after he practiced for 23 years as a family physician in Nixon and Floresville. In 1977, he joined The University of Texas-Houston Medical School as a professor in the Department of Family Practice and Community Medicine. "There, I learned to appreciate the teacher-learner process from both sides of the desk," Dr Nixon said. He served UT-Houston as director of the Division of Continuing Education, special assistant to the president for governmental and professional relations, and faculty associate at the Center for Health Promotion, Research and Development.

Besides his profession, Dr Nixon also has provided distinguished service for his country and community. He is a member of the Society of Medical Consultants to the Armed Forces, having served as civilian consultant in family practice to the Surgeon General of the Air Force. In 1985, President Ronald Reagan named Dr Nixon a member of the Board of Regents of the Uniformed Services University of the Health Sciences. A former chief of staff at Memorial Hospital in Floresville, Dr Nixon has served as vice president of the Nixon School Board, acting director of the Wilson County Health Department, and director of the South Texas Chamber of Commerce.

BEFORE YOU SIGN

Contract TIPS

Things you need to know

Austin attorney mediator Andre Hampton, JD, and the TMA Office of the General Counsel suggest an ideal managed care contract should:

- Provide that after termination of the contract and until the managed care organization has made medically appropriate referrals of patients who continue to need your services, including special circumstance patients (as defined by health maintenance organization and preferred provider organization laws), the payer shall pay your standard fees for services that you render to such patients.
- Prohibit the managed care organization from disclosing any information provided by you or about you in connection with any credentialing or peer review deliberations, unless such disclosure is otherwise required by law.
- At a minimum, incorporate provisions from Texas law governing the quality, utilization management, and due process standards for managed care organizations.

Source: TMA Physician Services. For more information about TMA Physician Services or to request a copy of the catalog, call (800) 523-8776, or (512) 370-1418; or e-mail physician_services@texmed.org.

House elects emeritus, honorary members

Two physicians were elected to emeritus membership and six physicians were elected to honorary membership by the Texas Medical Association House of Delegates.

Member emeritus status was conferred upon George G. Alexander, MD, of Bellville, and Margie B. Peschel, MD, of Fort Worth, for their exceptional and distinguished service to scientific or organized medicine.

Dr Alexander, a former president of TMA and the Harris County Medical Society, is known for his personal crusade to establish the Gulf Coast Regional Blood Center and to address the blood supply problems in Houston. He was a member of the Texas Delegation to the American Medical Association for 16 years, 4 of which he was chair of the delegation. Dr Alexander also has served as chair of the Rosewood General, Sam Houston Memorial, and Pasadena Bayshore hospitals. Founding chair of the Houston AIDS Alliance, Dr Alexander was the first recipient of the Outstanding Service Award presented by Hermann Hospital in Houston. He served for 20 years on the Harris County Hospital District Board of Managers. Dr Alexander is a World War II veteran, a retired colonel of the US Army Reserve, and a diplomate of the American Board of Family Practice.

Dr Peschel has served as president for numerous organizations, including the Tarrant County Medical Society (TCMS), Texas Society of Pathologists (TSP), South Central Association of Blood Banks, and the Tarrant County Society of Pathologists. She also has served TMA as secretary of the association and chair of the Committee on Health Careers and the Special Committee on Blood Banking and Transfusion. Dr Peschel is known worldwide for her expertise in immunohematology and blood banking and served as medical director of Carter Blood Center from 1976 to 1997. Her honors include TSP's George T. Caldwell Distinguished Service Award and TCMS's Community Service Award. Dr Peschel serves as adjunct professor of Tarleton State University's medical technology program and the nursing program at The University of Texas at Arlington.

Honorary members elected at TexMed '99 were Jim C. Burns, MD, West Columbia; Louis J. Girard, MD, Magnolia; Lowell J. Kepp, Jr, MD, Corpus Christi; Manuel L. Ramirez, Jr, MD, Corpus Christi; Clemens A. Struve, MD, Corpus Christi; and Stanley E. Thompson, MD, Richmond. ★

Jim Lincoln

TMA House of Delegates Vice Speaker Sue Rudd Wynn, MD, a devoted Aggie, humbly accepts a University of Texas notebook from TMA House of Delegates Speaker Tom Hancher, MD, who bleeds orange, for losing a bet made with Dr Hancher at interim session last November. The UT Longhorn football team squeaked by the Texas A&M Aggies 26-24, so Dr Wynn was forced to carry her papers in the burnt orange notebook throughout TexMed '99.

Delegates fill leadership positions

The Texas Medical Association House of Delegates chose cardiologist J. James Rohack, MD, as TMA president-elect and elected two new members to the Board of Trustees during TexMed '99. Dr Rohack, associate medical director for medical operations at Scott & White Health Plan in Temple and associate professor of medicine at Texas A&M University Health Science Center, will assume the TMA presidency during TexMed 2000 in San Antonio next May.

Temple cardiologist J. James Rohack, MD, was elected TMA president-elect.

A member and former chair of the American Medical Association Council on Medical Education, Dr Rohack has served as chair of TMA's Council on Medical Education, secretary of TMA's Board of Trustees, and TMA delegate to the AMA. He is a member of the American College of Cardiology Section Council on Cardiovascular Disease and The University of Texas Medical Branch at Galveston Alumni Association Board of Trustees.

New members of the Board of Trustees are Bohn D. Allen, MD, of Arlington, and Lyle S. Thorstenson, MD, of Nacogdoches. Dr Thorstenson will serve as the board's secretary. Dennis J. Factor, MD, of Dallas, and Frederick L. Merian, MD, of Victoria, were reelected to the board.

In addition, Earl L. Grant, MD, of Austin, assumed the duties as chair of the Board of Trustees. Dr Grant, who was the board's vice chair, succeeds By-

ron L. Howard, MD, of Dallas, as chair. Dr Howard completed 9 years of service on the board. Dr Merian replaced Dr Grant as vice chair.

Austin anesthesiologist Earl L. Grant, MD, assumed the duties as chair of the TMA Board of Trustees.

Priscilla Ray, MD, of Houston, was elected TMA secretary-treasurer. She replaces George E. Thannisch, MD, of Lufkin, who did not seek reelection. Tom B. Hancher, MD, of Columbus, and Susan Rudd Wynn, MD, of Fort Worth, were reelected speaker and vice speaker of the House of Delegates.

Elected delegates to the AMA were Drs Allen; Merian; Howard; Wynn; Hugh Lamensdorf, Fort Worth; Brian Eades, Amarillo; Wm Gordon McGee, El Paso; John P. Howe III, San Antonio; Carolyn A. Evans, Plano; Phil H. Berry, Jr, Dallas; and Charles W. Bailey, Jr, Houston. Elected alternate delegates to the AMA were Drs Thorstenson; Robert H. Emmick, Jr, Bryan; David C. Fleeger, Austin; Martin G. Guerrero, San Antonio; Robert T. Gunby, Jr, Dallas; Paul B. Handel, Houston; Ronald G. Munson, Mathis; Sheldon Gross, San Antonio; and Art Klawitter, Needville. Rodney B. Young, MD, Lubbock, will serve a 1-year term as alternate delegate from the Resident and Fellow Section. Sandeep G. Mistry, of Houston, will serve a 1-year term as alternate delegate from the Medical Student Section.

Elected to councilor positions were Drs William J. Deaton, Austin, District 7; Raymond C. Jess, Lake Jackson, District 8; Presley J. Mock, Jr, Pasadena, District 9; George S. Hoffman, Beaumont, District 10; and Joe R. Cannon, Abilene, District 13. ★

TexMed '99 Images

Ellen Wright Clayton, MD, JD, asks TexMed '99 general session attendees whether a physician should tell a patient's relatives about the patient's devastating genetic disease. During her ethics presentation, Dr Clayton, head of the American Bar Association Health Law Section's Clinical Ethics Group, discussed the potential grounds for imposing liability on physicians for damages caused by unwanted disclosure. "It is almost impossible to segregate everything that has possible genetic implications out of the medical record," said Dr Clayton, an associate professor of pediatrics at Vanderbilt University School of Medicine in Nashville and an associate professor of law at Vanderbilt University School of Law. "And keeping information out of the medical record opens both you and the patient to claims of fraud by the health insurer."

Jim Lincoln

TexMed '99 general session speaker Helen Hobbs, MD, discusses how genetics will affect practice in the next century through disease diagnosis, risk stratification, and individualization of treatment. "Genetics is definitely a roll of the dice," said Dr Hobbs, professor of internal medicine and chief of the Division of Medical Genetics at The University of Texas Southwestern Medical School at Dallas. "And how can we keep the game fair? That's going to be a very difficult problem. How can we keep people from loading the dice?"

El Paso infectious disease specialist and writer Abraham Verghese, MD, signs copies of his first book, *My Own Country: A Doctor's Story*, and his latest book, *The Tennis Partner: A Doctor's Story of Friendship and Loss*, following his keynote address at the TexMed '99 opening general session. Dr Verghese read excerpts from *The Tennis Partner* as he discussed addiction and suicide among physicians. "Pay attention to your feelings," Dr Verghese said. "Pay attention to the pain of your colleagues."

TexMed '99 Images

Several journalists were honored with the Anson Jones, MD Award for excellence in health medical communication during TexMed '99. From left are print winner Brian Wallstin, *Houston Press;* radio winner Rick Hadley, WBAP-Arlington; television winner John Hammarley, KDFW-Dallas; print winner Laura Beil, *The Dallas Morning News;* print winner Sue Goetinck, *The Dallas Morning News;* print citation of merit recipient Roger Witherspoon, *The Weekly Newspaper,* Dallas; Carolyn Evans, MD, former chair of TMA's Council on Communication, who presented the awards; and print citation of merit recipient Angela C. Boeckman, *Austin Family Magazine*. Not pictured are print winner Leslie Sowers, *Houston Chronicle;* television winner Angela Cain, KXAS-Fort Worth; print citation of merit recipients Jim Atkinson, *Texas Monthly,* Lesley Layton Tarpinian, *Round Rock Leader,* Charles Ornstein, *The Dallas Morning News,* and Jim Morris, *Houston;* and radio and television citation of merit recipients Patricia Gras, KUHT-Houston, Steve Ring, KBTX-Bryan, and Christi Myers, KTRK-Houston.

Following the TexMed '99 opening general session, TMA Past President John P. Howe III, MD, left, presented a plaque to Texas Medical Liability Trust (TMLT) Governing Board Chair Martin F. Scheid, MD, center, and Governing Board member Robert G. Thumwood, MD, right, in commemoration of TMLT's 20 years of success as the leading provider of medical liability coverage for Texas physicians. "We thank you for your kind words and your recognition of the 20th birthday of TMA's offspring," Dr Scheid said. "We appreciate the opportunity to sponsor part of this meeting." TMLT serves more than 9,400 physician policyholders in Texas.

Former TMA Board of Trustees Chair Byron L. Howard, MD, surprises Amy Wilson, who retired as executive director of the Texas Medical Association Alliance in March after 27 years of service, with a trip to Paris during TexMed '99. Ms Wilson told physicians, "My parting wish for you and the alliance is that you help them move on to the next level of support for medicine — that you involve them in what you do."

Robert Wilson of J.J. Jowdy Photography

Texas' own Ross Perot shares his views on medicine at the Texas Medical Association Alliance's dinner at the Dallas World Aquarium during TexMed '99.

US Sen Kay Bailey Hutchison (R-Tex) discusses issues impacting physicians with William Fawcett IV, MD, of Beaumont, during a TEXPAC 300 Club reception held at TexMed '99 in Dallas.

Students earn awards at TexMed '99

Medical students from The University of Texas Southwestern Medical School in Dallas took top honors in the TexMed '99 student and resident scientific poster exhibit competition.

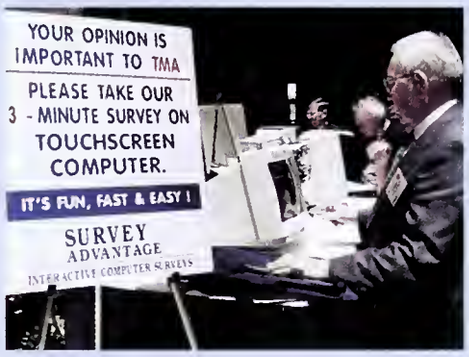
Thomas Neilsen earned the $300 first-place prize for his exhibit "Hyperspectral Imaging: A Novel Approach for Microscopic Analysis," while Edward D. Esplin won the $200 second-place award for "Mutations of the PPP2R1B Gene in Lung and Colon Cancer."

Sonja Veronica Cortez, a student at The University of Texas Medical Branch at Galveston, earned the $100 third-place prize for "The Learning Curve of a Medical Student Using the Non-Mydriatic Camera," and Tad Pierce, a student at the University of North Texas Health Science Center at Fort Worth, earned an honorable mention for his exhibit titled "PROMISE Speaker Program." ★

TexMed '99 Images

Robert Wilson of J.J. Jowdy Photography

Students from The University of Texas Southwestern Medical School discuss student issues with TMA Board of Trustees members at an ice cream social during TexMed '99 in Dallas.



Jim Lincoln

Plano gynecologist Gilbert Landis, MD, shares his opinions on the Texas Medical Association at TexMed '99.

TexMed '99 attendees participate in the American Medical Association EPEC program, part of TexMed's ethics educational track, which offered 16 hours of continuing medical education credit in end-of-life care. Along with six educational tracks, TexMed's new features included a second general session with Wayne Sotile, PhD, and his wife, Mary Sotile, MA, of Winston-Salem, NC, who discussed physician marriages and relationships with colleagues.

TMA Past President Mark J. Kubala, MD, of Beaumont, was elected president of the Texas Medical Association Foundation Board of Directors at TexMed '99. Other new foundation officers, who will serve through May 2001, include Emily Shelton, of Lufkin, vice president; Beverlee Herd, of Fort Worth, secretary; and Greg Winegardner, of Victoria, at-large member of the Executive Committee.

Sculpture displays doctor's reward

Jim Lincoln

The Doctor's Greatest Reward, a sculpture envisioned by the late Victor J. Weiss, Jr, MD, was unveiled at TexMed '99. From left are Byron L. Howard, MD, former chair of the Texas Medical Association Board of Trustees; John P. Howe III, MD, TMA past president; Belinda Weiss, widow of Dr Weiss; and sculptor Garland Weeks.

A bronze sculpture of a physician and his young patient has brought "some real humanity and softness" to the foyer of the Texas Medical Association building in Austin, said former TMA Board of Trustees Chair Byron L. Howard, MD, of Dallas, during the sculpture's unveiling at TexMed '99.

The sculpture, titled *The Doctor's Greatest Reward,* was produced with funds committed to the project by Victor J. Weiss, Jr, MD, before he died in October 1997. A San Antonio psychiatrist and former TMA Board of Trustees member, Dr Weiss wanted TMA members to have a visual reminder of the great tradition of caring for patients performed by Texas physicians.

Dr Weiss' widow, Belinda, members of TMA's History of Medicine Committee, and Dr Howard, a good friend of Dr Weiss, chose a design by Garland Weeks, a former official state sculptor of Texas from Marathon, to represent Dr Weiss' lasting legacy of caring. "It was selected for its touching interpretation of the physician's greatest reward — a well patient and the gratitude of the patient," Dr Howard said. The sculpture is on permanent display in the first-floor lobby foyer of the TMA building.

WEB SITES OF INTEREST TO TEXAS PHYSICIANS BY JOHANNA FRANKE

MedBytes

The Internet is spilling over with online health resources for you and your patients, but the Texas Medical Association Web site, at www.texmed.org, is there to help mop up in July's "MedBytes."

TMA Library links

TMA Library has created the "TMA Internet Gateway to Health Resource Links" to help health professionals and the public locate appropriate and authoritative health information. From TMA's home page, you can find the gateway by selecting "TMA Library & Resources" and locating the reference information section of TMA Library's main Web page. The links, which are provided for educational use only and are not intended to replace the advice of a health professional, are divided into the following 14 categories:

SEARCH TOOLS/MEDLINE — sites for searching the medical literature or the Internet for health-related information, such as PubMed, Internet Grateful Med, and MEDLINEplus.
REFERENCE SHELF — medical dictionaries and directories.
GOVERNMENT — state and national sites offering health and medical information for both physicians and patients.
CONSUMER/PUBLIC HEALTH — gateways to consumer health information on preventive medicine and a variety of diseases and conditions.
CLINICAL INFORMATION — large metasites organized for physicians offering a wide array of clinical information.
JOURNAL LINKS — links to many full-text journals and journal Web sites, including TMA Library titles.
HEALTH IN THE NEWS — tools for finding health topics discussed in newspaper, print, and TV sources.
CLINICAL TRIALS/EVIDENCE-BASED MEDICINE — a variety of information related to clinical trials, practice guidelines, and evidence-based medicine.
DRUG/PHARMACY INFORMATION — consumer and professional information specific to pharmaceuticals.
ALTERNATIVE HEALTH PRACTICES — complementary and alternative health care information for practitioners and the public.
HEALTH SCIENCE LIBRARIES — medical libraries throughout Texas.
HISTORY OF MEDICINE — resources for historical medical information.
PUBLISHING INFORMATION — copyright information, instructions to authors, and citation practices.
SPANISH LANGUAGE HEALTH SITES — consumer health information provided in Spanish.

TMA public and private resources

If your patients want to know what TMA can offer them, steer them to TMA's "Links to Materials of Interest to the Public" at www.texmed.org/ help/public.html. They will find resources such as health tips, immunization schedules, and TMA Library community services.

TMA members should consult the "Members Only" section of TMA's site to find "Materials of Interest to TMA Members," which includes legislative, medical insurance, and quality improvement information. While you're in "Members Only," check out "What's New on the TMA Web Site," a Web page containing links to the most important recent additions and updates to the TMA Web site. "Web Site Materials Available to TMA Members Only" shows you what you can't find in the public section. E-mail lists, TMA publications, managed care contract information, and TMA House of Delegates summaries, among other resources, are available in this section. All three of these online member resources can be accessed easily from the "Members Only" main page.

MedBytes is a quick look at new, or newly discovered, Web sites of interest to Texas physicians. The column also highlights features of the TMA Web site at www.texmed.org. If you know of some cool medical sites or have questions about how to use the TMA Web site, e-mail johanna_f@texmed.org. Publication of information about Web sites in this column is not to be considered an endorsement or approval by the Texas Medical Association of the sites or sponsors, or of any products or services involved.

UT exhibit features Ware/TMA collection

The Human Condition," an exhibit featuring prints from the Elgin W. Ware, Jr./Texas Medical Association Collection of Prints and Drawings Devoted to Medical Themes, is on display through August 8 at The University of Texas at Austin.

The collection is named after Dallas urologist Elgin W. Ware, Jr, MD, chair of TMA's History of Medicine Committee. Dr Ware and other committee members, along with Jonathan Bober, curator of prints and drawings at UT's Jack S. Blanton Museum of Art, established the collection in 1995. Today, the Ware/TMA collection includes more than 40 prints illustrating the profound connections between medicine, art, and printmaking from the Renaissance to the present (see "The Art of Medicine," February 1999 *Texas Medicine,* pp 34-46).

This exhibit, the first to present the Ware/TMA collection in its entirety, features Old Master prints by Albrecht Dürer, Francisco Goya, and Rembrandt van Rijn, as well as modern and contemporary works by Kathe Kollwitz, Robert Riggs, and Eric Avery, MD, of Galveston. A large number of prints from the museum's other holdings, including many masterpieces exploring the representation of the medical arts, also will be included in the exhibit.

The exhibit is on display in the temporary exhibition space on the second level of the UT Art Building on the northeast corner of San Jacinto Blvd and 23rd St in Austin. The museum is open to the public, free-of-charge, 7 days a week. Hours are Monday, Tuesday, Wednesday, and Friday, 9 am to 5 pm; Thursday, 9 am to 9 pm; and Saturday and Sunday, 1 to 5 pm; or by appointment. The museum is closed during all UT holidays. For recorded information about current exhibitions, programs, parking, and hours, call (512) 471-7324. For specific information about the Ware/TMA collection, call (512) 471-9208. ★

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- Was written by Austin physician Julie Graves Moy, MD, MPH
- Costs $10 for TMA members and $15 for non-members

To order a copy, contact TMA Library at (800) 880-1300, ext. 1541, or (512) 370-1541, or fax (512) 370-1634, or tma_library@texmed.org

TexasMedical Association

In Case You Missed It

By Melissa McEver

Do women need to receive more anesthesia than men do before an operation? Studying 274 patients undergoing surgery, scientists at DUKE UNIVERSITY MEDICAL CENTER found that female patients' wake-up times after surgery averaged 7 minutes, while male patients woke up after more than 11 minutes. The researchers speculated that women might be less sensitive to anesthetics or metabolize them faster.
(*Anesthesiology*, 5/99)

Children who sleep with room lighting at night may be more prone to nearsightedness than children who sleep in darkness, a recent report concluded. Dr Richard Stone and colleagues at the UNIVERSITY OF PENNSYLVANIA SCHOOL OF MEDICINE learned, after giving a questionnaire to parents of 479 children, that the children who had slept with light during the first 2 years of life had a greater occurrence of myopia than those who did not.
(*Nature*, 5/13/99)

A new report suggests that consuming dietary flavonoids may help protect postmenopausal women from coronary heart disease death. Dr Laura Yochum and colleagues at the UNIVERSITY OF MINNESOTA-MINNEAPOLIS discovered a 38% reduction in heart disease-related death among women with the highest category of flavonoid intake compared with women with the lowest. Dietary sources of flavonoids include fruit, tea, and soy products.
(*American Journal of Epidemiology*, 5/15/99)

Poor functioning of the cerebellum may play a major role in dyslexia, scientists at SHEFFIELD UNIVERSITY in England have found. The researchers monitored brain activity in young dyslexic men and compared it with a control group, finding that cerebellar activation in the dyslexic men was only 10% of that in the men without dyslexia.
(*Lancet*, 5/15/99)

Adolescents who are gay, lesbian, bisexual, or unsure of their sexual orientation are at much higher risk for suicide, a recent study found. Researchers at CHILDREN'S HOSPITAL in Cambridge, Mass, and THE JOHNS HOPKINS SCHOOL OF HYGIENE AND PUBLIC HEALTH in Baltimore, Md, discovered when interpreting survey results of public school children in Massachusetts that homosexual or bisexual students were 3.41 times more likely to report a suicide attempt.
(*Archives of Pediatric and Adolescent Medicine*, 5/99)

New TMA exhibit focuses on physician caricatures

Back in Edwardian and Victorian England, physicians often were subjects of caricatures much like politicians and movie stars are today. Several of those caricatures that appeared in *Vanity Fair,* the leading society magazine of that day, will be on display in a new Texas Medical Association Library exhibit.

"Caricatures in Medicine," which runs July 5 through October 30, features a print collection of these full-page chromolithographed drawings of prominent citizens, including scientists and physicians such as Louis Pasteur and Charles Darwin, as well as surgical pioneer Sir James Paget and Rudolf Virchow, known as the father of modern pathology.

The gallery is located in the first-floor lobby of the TMA building at 401 W 15th St in Austin. The exhibit can be viewed from 8:15 am to 7 pm, Monday through Friday, and 9 am to 1 pm on Saturday. The TMA building is closed on major holidays. For information, call Patty Mullins, special collections coordinator, in the TMA Library at (800) 880-1300, ext 1552, or (512) 370-1552; or e-mail patty_m@texmed.org. ★

Leitch, Reed honored with UT Southwestern chairs

S.T. "Buddy" Harris and his family have given The University of Texas Southwestern Medical Center at Dallas $500,000 to establish new chairs that honor two Texas Medical Association members the Harris family admires.

The S.T. Harris Family Chair in Breast Surgery honors Marilyn Leitch, MD, a general surgeon and medical director of the Southwestern Center for Breast Care, while the S.T. Harris Family Chair in Internal Medicine honors Gary Reed, MD, chief of general internal medicine at UT Southwestern.

The family's gift will be matched with funds from an anonymous donor, and each chair will be endowed with $500,000. ★

C O N N E C T T O T M A

HotLines

TMA switchboard (800) 880-1300

Impaired physicians (800) 880-1640
Call this 24-hour hotline to report information concerning physicians who may be abusing alcohol or other drugs, or who may be chemically addicted, psychiatrically impaired, or have other problems. All calls are confidential.

Insurance (800) 880-8181
The Texas Medical Association Insurance Trust offers life, health, disability, office overhead, personal accident, and other insurance plans and products to TMA members, their families, and office staffs.

Loans (800) 880-2828
TMA offers qualified medical students and residents low-interest loans. Call for general requirements and application procedures.

TEXPAC (800) 880-1300, ext 1362
The TMA Political Action Committee speaks on behalf of physicians through grassroots involvement, personal relationships with elected officials, and political campaign participation and contributions.

TMA Physician Services (800) 523-8776
TMA Physician Services delivers physicians and physician organizations an array of products and services to help them succeed in the changing medical marketplace.

Use the following prefixes plus @texmed.org to e-mail for TMA resources.

General Information	info
Continuing Medical Education	cme
Interspecialty Society Committee	isc
Medical Education	meded
Member Services	memberservices
Meeting Management	meetings
Physician Oncology Education Program	poep
Sneak Preview	sneakpreview
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American Physicians Insurance Exchange and Florida Physicians Insurance Company, Inc. have joined forces to offer national experience, local service, stability and commitment.

Editorial deems annual physicals unnecessary

Managed care companies should recommend periodic health exams instead of complete annual physical examinations for healthy patients, according to an editorial published in the May 10 *Archives of Internal Medicine.*

"More emphasis should be placed on focused examinations with screening for high-risk behaviors," said Paul R. Gordon, MD, of the University of Arizona College of Medicine in Tucson, in an interview with Reuters Health. "I would like to see minimal reliance on physical exam findings except for blood pressure, weight, and breast examination."

Based on his group practice, Dr Gordon estimates that annual physicals in the United States account for "more than 11 million potentially unnecessary visits per year." Dr Gordon and colleagues noted that the American Medical Association stopped recommending annual physicals in 1983, Reuters reported. ★

TMAF launches second community grants program

County medical and alliance societies have the opportunity to improve the health of their communities through the Texas Medical Association Foundation's (TMAF's) second Community Grants Program.

Societies can receive TMAF funding for programs that support a current TMA public health or science priority. The deadline for submitting proposals is July 30. Current TMA public health and science priorities include adolescent health, head injury prevention, cardiovascular health, and cancer prevention, among others. Programs may be executed in cooperation with other community organizations.

All county medical society presidents and executive staff, and alliance presidents and presidents-elect were mailed requests for proposals in May. If you need an additional copy or have questions, call TMAF at (800) 880-1300, ext 1664, or (512) 370-1664. ★

Physicians discuss organ donation with families

Nearly two thirds of Texas physicians have discussed their organ donation preferences with their families, according to an April 1999 Texas Medical Association continuous survey. This number has increased from the 54% of physicians who reported discussing this subject with their families in a 1997 Live & Then Give survey.

Survey results also show a significant increase in the number of physicians who say they discuss organ donation with their patients. In 1997, only a quarter of physicians reported those discussions, but that number increased to more than a third in 1998. According to the survey, family practitioners (75%) and general surgeons (64%) are most likely to talk to patients, and obstetricians or gynecologists (5%) and orthopedic surgeons (10%) are least likely to talk to patients.

More than half of the surveyed physicians said their spouses and they have signed organ donor cards or indicated on their driver's licenses that they wish to be donors.

According to survey results, TMA's Live & Then Give organ donation awareness program had little impact on a physician's personal decisions about organ donation, but had a significant positive effect on related knowledge and behavior. Because of the program, physicians are more likely to know how to initiate the donation process and to report related discussions with their own patients and families. ★

TIPS ON HOW TO PUT YOUR PATIENTS FIRST

BEST Practices

Austin psychiatrist Emilie A. Becker, MD, offers the following suggestion to help physicians put patients first.

"By far one of the most helpful things for my office was to send an anonymous questionnaire with a postage-paid envelope to my patients. I got lots of helpful suggestions and good feedback on office staff.

"It was also interesting to see the range of comments about myself. With presumably the same approach to my patients, some found me cold and calculating, and others found me warm and affable. Some found I never discussed side effects of medicines, others found I went too in-depth.

"It turns out patients did not mind the length of time it took to wait to see me, but they detested my waiting room."

Please send your suggestions for putting patients first and improving patient-physician communication to president@texmed.org.

TEXAS MEDICAL ASSOCIATION SEMINARS

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With special sessions for medicine and surgery, the hands-on format features roundtable discussions, answers to complex coding questions, and real-life-coding dilemmas posed by seminar participants. In addition you'll learn to audit medical records to ensure that your coding practices are in compliance with industry standards.

July 8: Abilene

July 21: Texarkana

August 10: Amarillo

** Medicine session is 8:30 am-noon and surgery session is 1-5 pm.*

For more information, call Heather with TMA Practice Management at (800) 880-1300, ext. 1411.

Fall conference program explores Internet uses

The Texas Medical Association, the American Medical Association, and Intel are teaming up to bring you the latest Internet tools for improving the delivery of health care in the form of a free all-day Web training session. The "Internet Technology Health Day" will be held on Friday, September 17, in conjunction with TMA's 1999 Fall Conference: Turning Points in Medicine, at the Renaissance Austin Hotel.

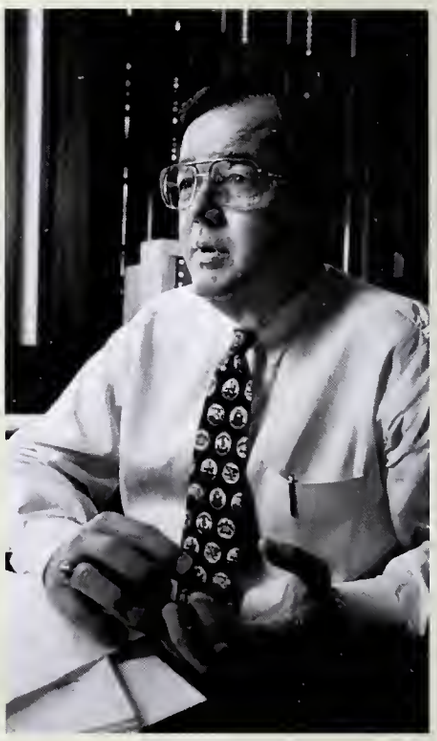
The session will cover emerging Internet trends, barriers to physician use of the Internet, and patient use of the Internet. The technology health day is an AMA and Intel pilot program of a mobile "roadshow" AMA hopes to bring to physicians throughout the nation. To register for "Internet Technology Health Day," call Paula Rigling at (800) 880-1300, ext 1450, or (512) 370-1450; or e-mail paula_r@texmed.org.

Registration for TMA's fall conference on September 18 is free for TMA members and invited guests, and $200 for nonmember physicians. For more information, call Amy Edwards, TMA special services, at (800) 880-1300, ext 1346, or (512) 370-1346; or e-mail amy_e@texmed.org. ★

Lowe center focuses on women's health

The new Lowe Foundation Center for Women's Preventative Health Care will help meet the health needs of women over age 40 at the Clinical Center for Women's Health at The University of Texas Southwestern Medical Center at Dallas.

The Lowe Foundation of Houston gave $1 million to the Southwestern Medical Foundation for UT-Southwestern to support programs focusing on osteoporosis screening, breast and female reproductive tract cancers, nutrition, exercise, coronary heart disease, urinary incontinence, psychological services, and breast cosmetic and reconstructive surgery. The center also is equipped to deal with the medical issues associated with menopause. ★



Jim Lincoln

State Sen David Sibley (R-Waco) will receive a 1999 Nathan Davis Award from the American Medical Association in Washington, DC, on July 20. Sen Sibley was one of two winners in the state senator category. The Dr. Nathan Davis Awards are named for the AMA's founder and are given to government officials whose contributions have promoted the art and science of medicine and the betterment of the public health.

COMMENTARY

(Editor's Note: In the June "Forum on Ethics" (p 26), John R. Pettigrove, MD, a Corpus Christi internal medicine and pulmonary disease specialist and a member of the Texas Medicine *Editorial Committee, addressed a letter to Tom B. Hancher, MD, speaker of the Texas Medical Association House of Delegates. In it, Dr Pettigrove said he sees blatant self-interest guiding the decision-making in financing health care, and asked, what is the moral and ethical basis of medicine? The following is Dr Hancher's response.)*

Dear Dr Pettigrove:

Thank you for your letter, "Where is the Outrage?" You, as have nearly all your peers, have had some frustrating encounters with managed care that all can sympathize with. The impact of managed care has been tremendous, and no one, not even this country internist (who has contracts with more than 50 companies), has been untouched.

However, I must disagree with your statement that what has gone wrong "is the death of outrage among our colleagues." When is the last time you attended a county medical society meeting, a reference committee session, a Council on Socioeconomics meeting, or yea verily, a Friday session of the House of Delegates? Now, there is outrage in action!

It may well be that I am exposed to a greater cross section of physicians than some, and as such, have been exposed to more than an occasional frustrated physician. One of the most rewarding experiences one can have is to see a physician who is exasperated beyond belief bring a special problem to TMA and see that problem dealt with in a serious and effective manner through our organization.

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Tom B. Hancher, MD
Speaker
TMA House of Delegates

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Just don't make me

Hospitalist programs have advantages, but medicine doesn't want them mandated

Regan Dunnick

Like gravity or like rain, economic markets affect everyone. Lately, the health care market has driven the use of hospitalists, whom medicine by most measures apparently has accepted — as long as their use remains a choice. But just watch the fur fly when anyone mandates their use.

This year, two large managed care plans in Texas tried to implement compulsory hospitalist programs but backed down in the face of physician opposition. Then, a bill to prevent any group from mandating the use of hospitalists never made it to the floor of the House of Representatives for debate in the 76th Texas Legislature. It died a quiet death. ➤➤

By Teri Moran, Senior editor

The implications in the dispute for medicine are huge, as well as for patients who want their own doctors to take care of them. Most affected are family practitioners, internists, and more recently, pediatricians.

There are an estimated 3,000 hospitalists nationwide, according to the 2-year-old National Association of Inpatient Physicians (NAIP), which also opposes mandatory hospitalist programs. Within 10 years, some 18,000 internists will be needed to meet the growing demand for hospitalists, estimates the American College of Physicians-American Society of Internal Medicine (ACP-ASIM).

Studies haven't confirmed how much, if at all, patients benefit from hospitalists' care because research is scanty. But studies have shown that hospitalists save money, mainly by cutting inpatient stays.

One study indicates that primary care physicians in both capitated and fee-for-service arrangements could benefit economically by referring their patients to hospitalists. Less time spent doing hospital rounds leaves extra time for the more lucrative outpatient visits.

During TexMed '99 in May, the Texas Medical Association House of Delegates went on record against the mandatory use of hospitalists. The House approved an amended resolution recommended by the Reference Committee on Socioeconomics. The resolution — originally submitted by Sara Bartos, MD, of the Texas Academy of Internal Medicine — says TMA opposes mandatory hospitalist programs and continues to support voluntary programs "as deemed appropriate by physician-led policymaking bodies advising health plans, institutions, and other entities."

The reference committee report to the House says that TMA does not object to the concept of hospitalists, who have the potential to improve clinical outcomes, quality of care, and patient satisfaction, while also appealing to numerous office-based physicians who want to dedicate more time to office patients.

However, the report says hospitalist programs also can compromise continuity of care, increase miscommunication between the hospitalist and primary care physician, erode office-based physicians' inpatient clinical skills, and cause physicians who relinquish the right to treat their hospitalized patients to lose their hospital staff privileges. Voluntary programs allow physicians to address the unique needs of their patients and practices, allow patients to choose who will provide their inpatient care, and assure physician "buy in" that results in patient acceptance and support, the committee report says.

"This issue is not about whether hospitalists are good or bad or whether they should exist in the marketplace. It's about whether their use ought to be voluntary or mandatory."

The Texas battle

CIGNA HealthCare of Texas, which insures some 245,000 people, recently proposed a compulsory hospitalist program in its 33 Houston-area hospitals. When physicians loudly objected, CIGNA said it would allow physicians to opt out of the program if they notified CIGNA in writing by May 1.

When Humana Inc proposed a similar plan in Austin, it gave physicians just 1 week's notice to opt out. Again, physicians protested and Humana extended the period another month.

Health insurers and managed care plans clearly are motivated to cut costs, and some health maintenance organizations (HMOs) already have demonstrated that they would implement mandatory hospitalist programs if they could.

No HMO went on public record to oppose the Texas bill that would have prevented insurers from mandating hospitalists, nor did the Texas Association of Health Plans (TAHP). No one testified against the bill in legislative committees.

But Aetna, Humana, and an independent practice association (IPA) in the Houston area hired a number of prominent lobbyists. Legislators never got the chance to vote on the bill because the House Calendars Committee didn't schedule it, which is a tried-and-true bill-killing method.

If it had reached the floor of the House, the bill would have passed overwhelmingly "simply because the opposition's point of view doesn't hold water," said Alfred Gilchrist, a TMA lobbyist. "This is about whether patients can have their own personal physicians follow them to the hospital or whether they have to be seen by someone they've never met before."

Tom Banning, a spokesperson for the Texas Academy of Family Physicians, says the academy does not oppose hospitalists. "This issue is not about whether hospitalists are good or bad or whether they should exist in the marketplace. It's about whether their use ought to be voluntary or mandatory."

Although the bill didn't pass this legislative session, Mr Gilchrist believes it may become popular next session. "It's going to be very interesting to hear the opposition's point of view — publicly — because legislators didn't get to hear that. The bill was killed without public debate."

Will any Texas HMOs try to force hospitalist arrangements again? "We certainly hope they don't," Mr Banning said. "The HMOs have argued, 'Why do you need this bill? No one is implementing mandatory programs right now.' But that certainly doesn't mean they won't turn around after the session is over and try again."

And if they do try, Mr Banning added, "it'll simply give us more ammunition next session."

While managed care lifts another sword over physicians' heads and again positions itself to restrict choice, the house of medicine has been busy trying to process and evaluate the explosive growth of hospitalists.

Who is a hospitalist?

Before NAIP physicians coined the name "hospitalists" to describe them-

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selves, there were plenty of physicians who cared primarily for inpatients. One large multispecialty group in Florida has been using hospitalists since 1987, and in California, where managed care market penetration is high, hospitalists are commonplace.

San Francisco internist Robert M. Wachter, MD, helped form the NAIP and defined hospitalists as "physicians who spend at least 25% of their professional time serving as the physicians-of-record for inpatients, during which time they accept 'hand-offs' of hospitalized patients from primary care providers, returning the patients back to the care of their primary care providers at the time of hospital discharge."

According to the American Academy of Family Physicians (AAFP), hospitalists evolved in four stages. In the first stage, primary care physicians took care of their own inpatients. In the second, primary care physicians formed groups and everybody took turns on call. In stage three, teams of inpatient physicians were established, but their use was optional. In the last stage, the teams became mandatory.

Satisfying a need

One reason hospitals like the idea of hospitalists is because call schedules have always been a headache for them, says San Antonio pulmonologist John R. Holcomb, MD, who presented a lecture on the growth of hospitalists at TexMed '99. "We all know how difficult it sometimes can be to get a patient admitted, and that has always been a sore point for hospitals. They haven't been able to fill that niche in a way that makes people happy, but hospitalists do." Dr Holcomb is part of a group of critical care physicians and he also runs the case management and quality assurance programs for Methodist Health Care Systems. He describes himself as an objective observer of the hospitalist phenomenon.

Hospitalists also provide cost-savings for hospitals and insurers. One of the few studies that looked at the impact of hospitalists on inpatient care showed that the patients had shorter lengths of stay, lower readmission rates, and reduced costs of care compared with patients under the care of their primary care physicians.

"We all know how difficult it sometimes can be to get a patient admitted, and that has always been a sore point for hospitals. They haven't been able to fill that niche in a way that makes people happy, but hospitalists do."

Researchers followed more than 3,000 patients at Western Pennsylvania Hospital in Pittsburgh. Half of the patients studied had been admitted and cared for by primary care physicians before a hospitalist program began, and half had been admitted and cared for by hospitalists. Hospitalists' patients had a median length of stay of 5.01 days, compared with 6.01 days for the prehospitalist group. The patients of hospitalists had a 14-day readmission rate of 4.64 per 100 admissions, compared with 9.9 per 100 admissions for the prehospitalist patients.

The average cost of care per patient for hospitalists was $5,258, compared with $6,275 for the nonhospitalist physicians.

Although the research is meager, it has been persuasive enough to convince health plans, university systems, and large physician groups to use hospitalist programs.

Far from booting patients out of hospitals prematurely to save a few bucks, hospitalists shorten stays mainly by always being right there at the hospital, says Galveston internist and hospitalist

Michael O'Malley, MD. "If an x-ray is ordered in the morning and is read by 10 am, I can go see that x-ray and, if needed, schedule a biopsy for that morning. Whereas typically, the primary care physician might not come back to the hospital until 5 pm and may have to scrap around to get the biopsy done, perhaps having to wait until the next day. That's where we shave off hospital days."

Not only do hospitals and insurers want shorter stays, "you have to remember that patients especially don't like being in the hospital any longer than is absolutely necessary," Dr O'Malley added.

Another justification for hospitalists follows the "practice makes perfect" adage. "Theoretically, they're better trained to treat acute disease than the average generalist," said Houston internist Robert L. Donald, MD, who says he is delighted that hospitalists have freed him to concentrate solely on clinic work, now his favorite way to practice medicine. "I believe that adage bears out in most cases, because it only makes sense that someone who treats acute disease day in and day out will become more accomplished at it."

Wait a minute, though

Many physicians have echoed the concerns that generalists could ultimately suffer an erosion of their clinical skills as a result of the growth of hospitalists and that the whole idea sacrifices patient satisfaction and continuity of care. The AAFP and ACP-ACIM have deliberated on this matter for the last few years, publishing numerous articles about the issue in their specialty journals (see the AAFP Web site at www.aafp.org, the ACP-ACIM Web site at www.acponline.org, and the NAIP Web site at www.naiponline.org).

The AAFP conducted several member surveys and in one 1998 survey of its constituent chapters found that 73% of the respondents were concerned that if some family practitioners voluntarily gave up their inpatient privileges, other family physicians might be negatively affected.

In another minisurvey, the AAFP found that 53% of family physicians

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had not been affected by the hospitalist trend. The bottom line so far, said AAFP President-Elect Bruce Bagley, MD, is that "most family physicians who dropped their privileges did so voluntarily, and they're not upset about it."

Again, although a patient poll hasn't been undertaken, patients seem to not be all that bothered by hospitalist care. Many of them know well ahead of time that if they are hospitalized, their primary care doctors won't be treating them.

Dr Donald's patients are all Medicare patients, who are all told up-front about the clinic's hospitalist system. "Sometimes they don't like the idea, but most do not object strenuously," he said. Dr O'Malley says he rarely faces indignant patients. "Every now and then a patient will say, 'You mean my doctor's not coming to see me?' And I'll tell that patient that his or her doctor might come by, but that we specialize in taking care of people who need to be in the hospital. Patients are usually okay with it after that."

Surprising dollars and cents

Amid concerns about physicians losing revenue from hospital care comes a report that shows in cold, hard numbers that referring patients to hospitalists actually earns physicians money, whether they're in fee-for-service or capitated arrangements.

According to market surveys by the Health Care Advisory Board, a Washington, DC, health care think tank, a typical physician in a capitated contract stands to gain some $46,775 per year by not visiting the hospital and using that time to see more outpatients. A fee-for-service physician would gain about $53,478 annually doing the same. Those amounts are based on a 15-minute one-way trip to the hospital to make 9.6 visits for 4.5 hours per week. Those gains also assume that capitated physicians draw $11.98 per member per month and no reimbursement for a hospital visit, while the fee-for-service physician draws $63.47 per inpatient visit.

"Those figures are truly eye-opening," Dr Holcomb said. "But you have to remember that somebody has to pay the hospitalist." In some models, the capitated physician might surrender a percentage of capitation or, in other models, a multispecialty clinic might pay the hospitalist a salary. "Everybody typically still comes out ahead," he added.

"That's the biggest challenge for the growing hospitalist movement," Dr O'Malley said. "Who's going to pay for the services?"

Eventually, the emerging hospitalist specialty will attract peer-reviewed study, and Dr O'Malley welcomes the focus. He says that hospitalists' availability to patients and their constant attention to critical care guidelines will likely reduce the kind of variability in critical care that compromises quality. ★

"That's the biggest challenge for the growing hospitalist movement. Who's going to pay for the services?"

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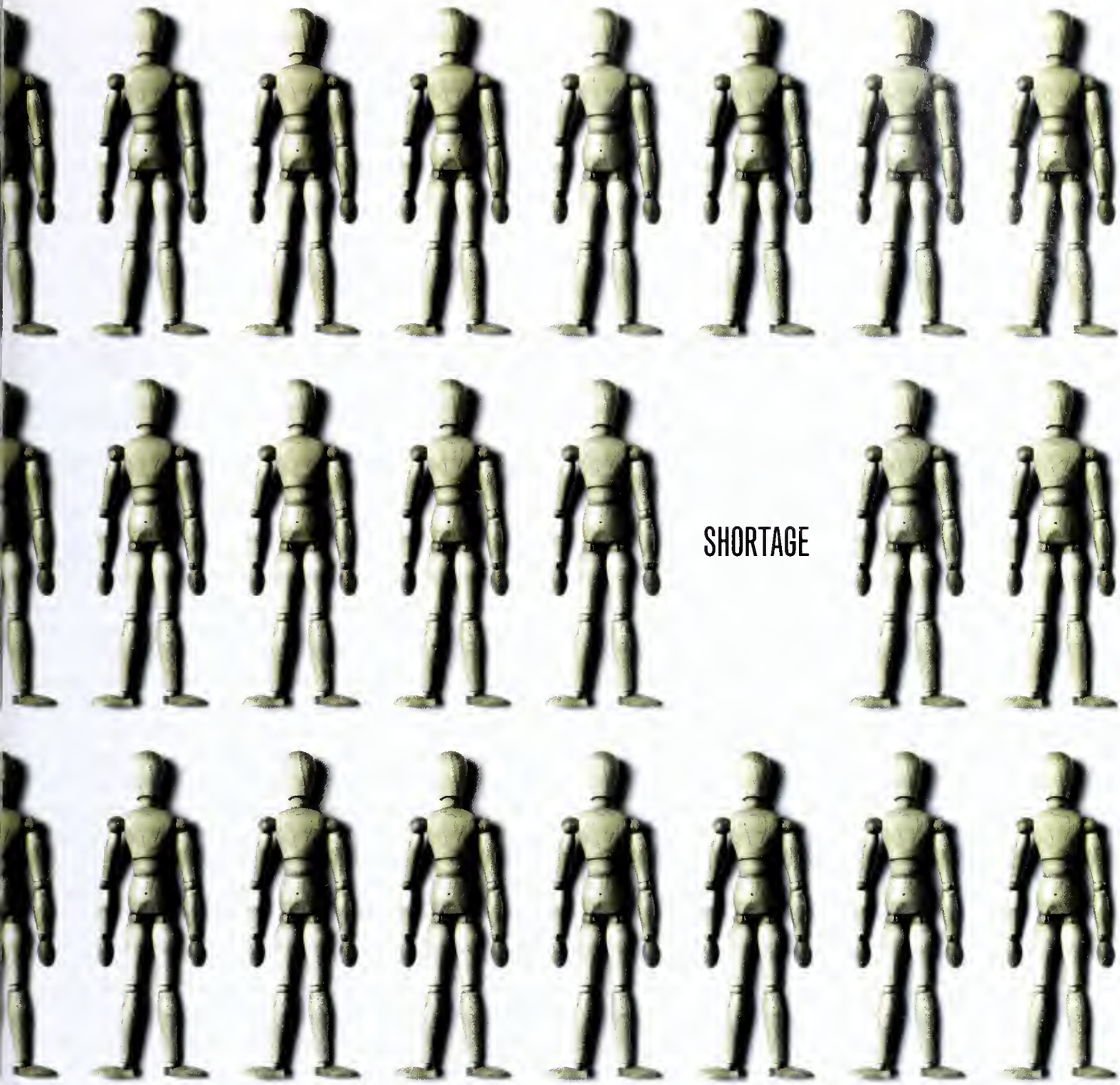


AMID SURPLUS

Getting the right doctors in the right places is critical in the paradoxical world of the physician workforce

By Monica Maldonado, Associate editor

The models for assessing Texas' physician workforce supply and demand are as baffling as the blueprints for the space shuttle. It literally takes a computer to unravel the input variables and interpret the output data to come up with a number that is followed immediately by a series of parenthetical determinants. Conditional statements abound, with the biggest, most problematic being "if all else stays the same."

But nothing stays the same in Texas, a geographic area so large it has two time zones and takes a full day of light to cross. Texas is the second-fastest growing state in the country and, in 30 years, the face of its population will be markedly different. In every aspect of their lives, not just in health issues, Texans can either feebly address emerging challenges with the same tired tools or study the issues and empower themselves with new tools that meet these challenges head on.

Assessing physician workforce needs, though certainly daunting, is the first step in confronting this issue. It's not just a matter of counting, but rather a series of projections based on the best estimations. Determining how to supply that demand is the second step. In this endeavor, the challenges are substantial, the biggest being money. Somehow, through huge mathematical efforts, the Texas Medical Association has been able to project the state's physician requirements through 2005 — if only the story stopped there. Behind this seemingly innocuous projection are controversial methods, results, and predictions that many believe are open to interpretation. After all, it's not just that the number of physicians is right but also that the right kinds of physicians with the right skills are in the right places and at the right price. And the chance of getting 20 million Texans to agree on what is the right way to meet their physician requirements is about as good as the chance of getting them all aboard that space shuttle.

The latest projections

Early this year, TMA's Division of Medical Education, at the request of the TMA House of Delegates, completed a study on the physician workforce needs of the future and their implications for medical education, making use of the latest computer model for projecting physician requirements (see "Modeling the Future," opposite page). For a copy of the study, call (800) 880-1300, ext 1434, or (512) 370-1434.

According to that study, recent licensing trends and attrition rates indicate that by 2005 Texas will have 37,587 physicians. Using the model to predict physician requirements, TMA found that Texas will need 35,973 physicians. According to these numbers, Texas will have 1,614 more physicians than it needs come 2005.

This conclusion caused the House of Delegates in May to reaffirm its workforce policy of no new medical schools and no increases in class size. The study was passed along to the Texas Legislature to offer guidance on its policy decisions.

This supply prediction assumes that the number of those entering medical school, the number acquiring residency training, the number obtaining their licenses, and the number remaining in the state after training — per year — will remain the same. Also, the demand prediction is offset by the projection of physician assistants, advanced practice nurses, podiatrists, optometrists, psychologists, clinical social workers, chiropractors, and acupuncturists. If projections for these professions were removed from the model, the state would need an additional 9,300 physicians in 2005.

"We believe people should have access to health care within 20 to 30 miles of their homes, but we realize that in some parts of Texas that is just not possible."

Even this slight growth in the number of practicing physicians — 17% between 1998 and 2005 — is significant, especially when you consider that the population rate of increase in that same period is approximately 16%, according to numbers from the US Census Bureau and the "Texas State Health Plan: 1999–2004." Historically, the growth rate in the number of physicians has surpassed the growth rate of the population. Looking back further, between the years 1973 and 1998, the growth rate in the number of physicians in Texas was 170%; for those same years, the growth rate for the population was 64%.

Concern over an oversupply of physicians is a national issue. In 1997, the American Medical Association led a coalition of five medical and physician organizations to address physician workforce and funding through the Medicare program. The AMA feared an oversupply of physicians would lead to "the underemployment and unemployment of physicians," according to the February 1997 consensus statement.

Marcia Collins, director of medical education policy for TMA, says the bigger problem would be underemployment. "When physicians can't maintain a practice, it becomes hard for them to maintain their skills," Ms Collins said. Another dangerous scenario can occur if physicians begin to generate a higher demand for their specialties just because they're there. As James Rohack, MD, of Temple, cardiology professor at Texas A&M University College of Medicine and president-elect of TMA, explained, "This can lead to the utilization of services that may not be absolutely necessary."

Some believe that as urban markets become saturated with physicians, the underused doctors will trickle down to the rural, underserved areas. But Ms Collins says that occurs less often than one would think "because the problems with operating a practice in the rural areas still exist."

An indisputable fact of oversupply is that it produces skilled professionals — at a high cost to taxpayers — who aren't needed. In 1997, Medicare paid $6.8 billion to teaching hospitals for direct and indirect costs associated with intern and resident training programs. In a 1997 report titled

"The Balanced Budget Act: Implications for Graduate Medical Education," supported by The Commonwealth Fund, author James A Reuter, ScD, of Georgetown University, wrote that Medicare's open-ended subsidies for graduate medical education (GME) were a major factor in the oversupply of physicians. The Balanced Budget Act attempts to use Medicare payments to reduce the growth and total number of GME training slots, while maintaining the current levels of training for primary care physicians. Based on the provisions of the act, the Congressional Budget Office expects a 3% reduction in the number of residency slots receiving Medicare funds. Dr Reuter's report said this number is "extremely modest," considering that projections by such organizations as the Council on Graduate Medical Education suggested the need to reduce these slots by one quarter to one third.

When having enough isn't enough

Predicting the absolute number of physicians Texas will have and need in the coming years is well and good, but the state's unique demands require Texans to delve further into what they need. When the state is broken down into groups of individuals, each with different needs, and those numbers are compared with the physicians in the workforce who can address those needs, the differences are significant enough to warrant special attention.

Historically, providing medical access for people who live in rural areas has been a problem. Only 15% of Texans live in rural areas, but these 3 million people are spread across 82% of Texas' land. The TMA report found that only 8% of Texas physicians practice in rural areas, which would lead one to believe the state should get more physicians out there fast. But many of these areas have too few people for a physician to maintain a practice, so alternative methods of health care are often used.

The authors of the TMA study found that 22 Texas counties did not have a full-time physician, but that 13 did have either a physician assistant or advanced practice nurse at a health clinic supervised by a physician part of the time. They also found physicians or other health care professionals practicing in neighboring counties. This led members of the Committee on Physician Distribution and Health Care Access to look into defining areas — not necessarily accounting for county lines — as primary care service areas. "We believe people should have access to health care within 20 to 30 miles of their homes," said emergency medicine specialist Diana Fite, MD, of Houston, former chair of the committee, "but we realize that in some parts of Texas that is just not possible."

Recently, interest in placing training programs in rural or underserved areas has increased. At press time, legislation adding an extension campus in Laredo of The University of Texas Health Science Center in San Antonio and an allied health campus, being developed by the Nueces County Medical Society and the Texas A&M University System Health Science Center, in Corpus Christi, was awaiting the governor's signature.

The problems associated with practicing in rural areas are well known. Physicians who practice there can lack support, such as a referral network of health care professionals. Physicians usually have more intimate relationships with their patients, who also are their neighbors. Because of this, they often work longer hours, sometimes treating and advising patients when they're off-duty and out of the office.

"Historically, and it's probably true to this day, when we talked about recruitment and retention of physicians to rural areas, we've probably really meant just recruitment," said Sam Tessen, executive director of the Center for Rural Health Initiatives. "Only recently have we begun to recognize that there are a lot of factors that can proactively influence retention."

Of the center's many programs to encourage students to choose rural areas for their residencies or practices, the ones Mr Tessen believes will be most effective in influencing physicians to stay in the rural areas are those that encourage

Modeling the future

Computer models for predicting physician workforce requirements date back 20 years. When the Texas Medical Association decided to try one out for Texas, it chose the latest, most technologically advanced and easiest to use: the Integrated Requirements Model-Release 2.0 developed by Vector Research, Inc, with a contract through the federal Bureau of Health Professionals. TMA is among the first in the nation to use this model.

The Integrated Requirements Model has a number of advantages over previous models. For one, this is the first to be adapted, and adaptable, for state use. Also, it runs on a personal computer, comes preloaded with Texas and national data that can be changed by the user, and includes the ability to run projections for not only physicians but also for 12 other health professionals in 18 specialty areas.

The output data rely heavily on future state demographics, which TMA acquired from the Texas State Data Center at Texas A&M University. The model takes into account a person's age, gender, geographic location, and health insurance status, and integrates this information with historical data on the people in these various categories to predict a person's health status and ability to access health care services. It then takes historical physician supply data from the Texas State Board of Medical Examiners and insurance data from Medicare, Medicaid, private insurance, and the uninsured and throws this information into the equation.

Because TMA was among the first to use the model, it had to work through a number of bugs, which, according to Marcia Collins, director of medical education policy for TMA, didn't affect the overall program. "We really took the model for what it was," she said. "It wasn't perfect but it was far better than any of the other models available at the time."

local community involvement. "What we're discovering is that health care is an integral part of the economic infrastructure," Mr Tessen explained, "and when the community gets involved with the recruitment process, it becomes invested in the physician. This can help the doctor build his or her practice, and help the retention potential."

Mr Tessen also believes medical schools should be obligated to explain the unique challenges of practicing in rural areas and maybe even expose students early to these areas. He also recommends that the state recognize the financial limitations of rural areas that are struggling to keep public schools open and work with the communities to retain physicians after the costly process of recruiting them. Mr Tessen predicts the state might, in some way, develop a physician relief service that would send stand-in doctors to these rural areas so that the presiding doctor can take continuing medical education courses or maybe even a vacation. Also, the recent development of rural community-based health networks may signal a change in the approach these areas are taking to health care.

The physician of the future

It stands to reason that with the growth of managed care in Texas comes the need for more primary care physicians. For years, physician workforce studies have emphasized the need to increase the number of primary care doctors. Nationally, many groups have set the goal of a 50:50 ratio for primary care to non-primary care physicians. The 1998 TMA study shows that Texas had a 44:56 ratio and that medical students are showing more interest in training in primary care specialties. Compared with 1995, the number of family practice residency slots filled in the 1999 match process has increased by 25.

The provisions of the Balanced Budget Act of 1997 may marginally increase the number of primary care residency slots. Those provisions, once fully implemented, will expand the types of entities eligible to receive Medicare direct medical education (DME) funds to include rural health clinics, community centers, and Medicare managed care plans, which traditionally have more primary care physicians than specialists. In the past, Medicare DME funds could only be made to hospitals, but since these host a large number of specialists, this method could have been supporting indirectly the imbalanced ratio of the number of specialists to primary care physicians.

So as Texas begins to incrementally gain more primary care physicians and place them in rural areas, will its needs be met? Some say they won't. Just as they like their political representatives to reflect the population of the state, some Texans also like their physicians to share their cultural backgrounds. More than any other physician workforce issue, determining the number of physicians to serve the racial and gender makeup of the state is contentious. Some people look at the discrepancies of representation among gender, race, and other categories, and believe that ideally Texas should have more female Hispanic primary care physicians practicing in rural areas.

Within the past 10 years, a gradual gender shift in the number of physicians has occurred (13% female in 1988 compared with 18% female in 1998), and this year about 4 out of every 10 medical students are women. As for the race issue, the explosion in the Texas Hispanic population will soon prompt us to reconsider our definition of "minority." The Texas State Health Plan, produced by the Statewide Health Coordinating Council, predicts that by 2010 the Texas population will be 40% Hispanic and 10% African American.

"The hope is that these programs for minorities will address the 'brain drain' of talented, qualified minorities who are leaving the state."

In 1998, the state's population was 30% Hispanic, with only 10% of physicians being Hispanic. Black representation fared worse, with only 3% of the physician workforce being African American, compared with 11% of the population.

The 1996 *Hopwood* ruling no longer allows medical schools to use race as a factor for admission, so across the state, private scholarship and incentive programs are being offered to qualified minorities. "The hope is that these programs for minorities will address the 'brain drain' of talented, qualified minorities who are leaving the state," Dr Rohack said.

TMA's Minority Scholarship Program recently awarded scholarships to three Texas medical school students. The potential for aiding Texas' workforce problems by tapping into the Hispanic population has been underused so far. Historically, physicians who come from rural areas are more prone to return there to practice, and a large portion of the burgeoning Hispanic population is located in rural areas.

Speaking from the point of view of a Hispanic physician who sees mostly Hispanic patients, Reynaldo Godines, MD, of Laredo, believes medical schools need to look beyond test scores when judging students. It takes more than the MCAT (Medical College Admission Test), he says, to determine which students might choose to practice in rural areas and where more Hispanics live. "The patient is not going to give a hoot about test scores if he or she has a physician who is a skilled and devoted practitioner," said Dr Godines.

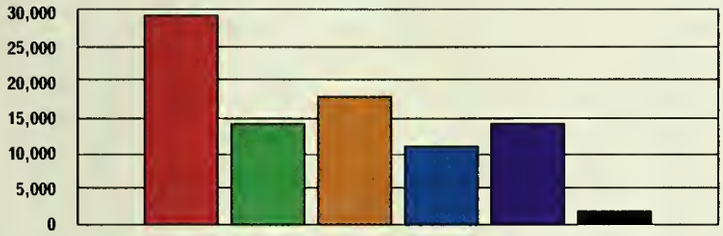
Supplying the demand for physicians

Tracking students entering Texas medical schools to see how their training plays out would be helpful. Hopefully, they could be directed to areas where they're needed most. Instead, the paths from their first year to where they take their residency training and where they choose to practice can only be estimated.

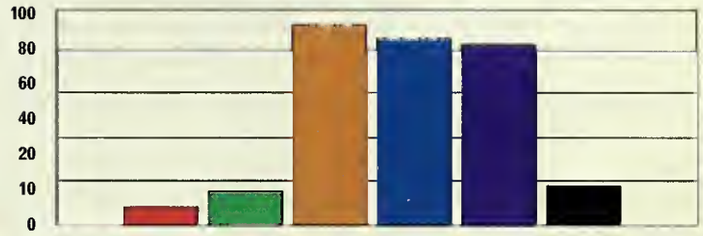
As of 1998, only 43% of Texas physicians were trained in Texas, and the number of physicians produced by Texas medical

Physician workforce and medical education at a glance

1998 physician workforce

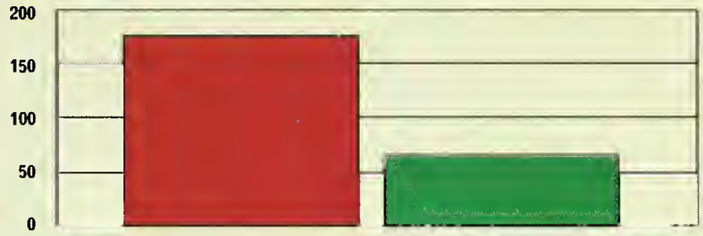


Texas-licensed physicians with an active in-state practice	32,101
Patient care physicians	28,956 (90%)
Primary care physicians	14,209 (44%)
Non-primary care physicians	17,892 (56%)
Physicians in solo practice	10,748 (34%)
Physicians in group practice	14,328 (46%)
Osteopathic physicians	1,759 (5%)

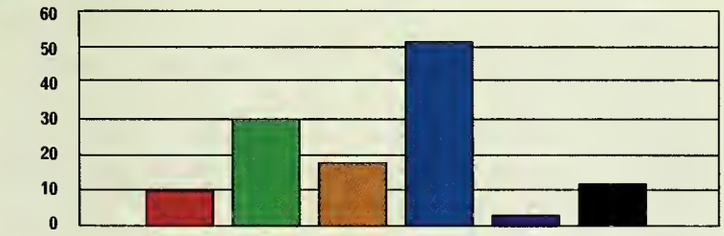


Physicians in rural areas	2,472 (8%)
Percent of population in rural areas	15%
Physicians in urban areas	29,629 (92%)
Percent of population in urban areas	85%
Percent of Texas land considered nonurban	82%
Number of Texas counties without a full-time physician	22 (9%)

Graduates of Texas medical schools	43%
Graduates of other US schools	35%
Graduates of international medical schools	22%

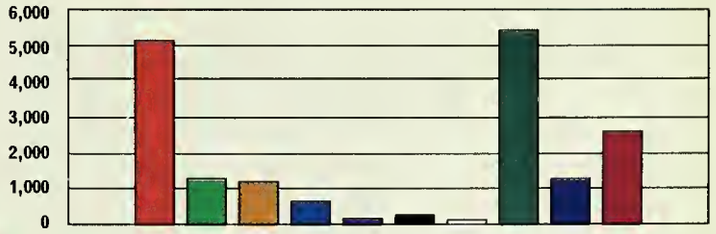


Rate at which the number of practicing physicians in Texas has grown since 1973	170%
Rate at which the Texas population has grown since 1973	64%



Hispanic physicians	3,096 (10%)
Percent of Hispanics in Texas population	30%
Female physicians	5,913 (18%)
Percent of females in Texas population	51%
African American physicians	987 (3%)
Percent of African Americans in Texas population	11%

Physician education pipeline



Fall 1998 total enrollment in Texas medical schools	5,155
Fall 1998 entering class	1,274
1997–1998 graduates	1,231
Total Hispanic enrollment	697 (14%)
Hispanic entering class	159 (13%)
Total African American enrollment	240 (5%)
African American entering class	57 (4%)
Total 1997–1998 residents in training	5,492
First-year residents	1,327 (24%)
Primary care residents	2,564 (47%)

All numbers prepared by the Texas Medical Association, February 1999.

schools has been declining for the past 5 years. On the other hand, Texas medical schools rank in the top 10 nationally for the number of graduates who plan to practice in the state in which they are trained. In addition, the Texas State Board of Medical Examiners reports that the number of out-of-state physicians seeking licenses to practice here will continue to increase.

In addition to the licensed physicians trained in Texas and other states, it's important not to overlook the health care being provided by physicians-in-training, who serve an important population in our state — the growing number of uninsured. In 1994, Texas had the highest number of uninsured in the country, and that group has come to rely on academic health science centers for their health care.

Here lies the problem: In the past, health science centers have been able to shift to private insurers the cost of caring for the uninsured or underinsured. According to the study performed by Dr Reuter, a congressional commission found that in 1995, academic hospitals charged private insurers almost 24% more than actual costs. But as health maintenance organizations (HMOs) become more aggressive in entering the market, their practice of negotiating smaller payment rates with in-network physicians and hospitals has stripped teaching hospitals of patients. Without having insurers that reimburse at fee-for-service rates, fewer funds are available to pay for those who can't or to pay to train physicians.

The 1997 Balanced Budget Act didn't help. By reducing the amount of money that Medicare provides these schools, the act in effect is forcing them to cut back on research, training, and the care provided to indigents. "The Balanced Budget Act has had a tremendous, deleterious effect on academic health centers," said John Stobo, MD, president of The University of Texas Medical Branch (UTMB) at Galveston. In April, UTMB reported that it would have to cut its costs for fiscal year 1999 by $40 million. UTMB may be unique in Texas in that it is the only UT health component that owns its hospital and cannot raise taxes from a health district to cover its expenses. This might be why UTMB is feeling the hits from the Balanced Budget Act first. "But I can assure you that everybody's going to feel it," said Dr Stobo.

This year, the UTMB hospital closed 170 beds and laid off 341 employees. "We have this historical mission of providing health care to the poor of Texas," said Dr Stobo, "but given the financial climate, we no longer have the income to offset that cost." Dr Stobo reports that last year, UTMB treated uninsured patients from 236 Texas counties, adding that of its 70,000 outpatient visits, 43% were uninsured, and of the 37,000 inpatient discharges, 23% were uninsured. In the Houston-Galveston region, one out of every three persons is uninsured.

"One of the problems here has been that the major driver for the training programs in residencies and fellowships has been the clinical load, not educational objectives," said Dr Stobo. "The discussion concerning the source of monies for training hopefully will force programs to define their educational objectives and size their programs to fit those objectives."

UTMB is setting up alternative systems with the Galveston County Health Department for caring for indigent patients that would allow patients to obtain their primary care off the UTMB campus, then go to the health science center for secondary and tertiary care. In the meantime, Dr Stobo says the school is beginning to rethink the number of residents it trains. Relying on Medicare for the bulk of funding for graduate medical education has been a mistake, he says.

"If you're doing something for the public good, you have to have public accountability. That's appropriate, and I think it's going to shape academic health centers in the future."

As government agencies and medical schools rethink this method, one possible solution to the problem has been posed. Called the "all-payer" mechanism, this proposal would set up a trust fund to finance physician specialty training. Contributions from Medicare, Medicaid, HMOs, and other insurers would make up the trust fund. But, as Dr Stobo explains, this would bring up two potentially contentious situations. First, you would have to know the cost of medical education, which he says is high enough to take some people by surprise. Second, you would have to make these programs accountable to those who would be funding them. "If you're doing something for the public good, you have to have public accountability. That's appropriate, and I think it's going to shape academic health centers in the future."

Thinking locally

Recognizing the need to balance Medicare's traditional funding of non-primary care physician training with the need for more primary care doctors, state programs are seeking other methods of funding primary care graduate medical education. The Texas Higher Education Coordinating Board asked this year's legislature for about $28 million for each fiscal year 2000 and 2001 for six programs that historically have provided funding for primary care residency program enhancements. The money will allow state support of graduate medical education to continue at about the same rate as the current biennium. The governor was expected to sign the bill before June 20.

According to Dr Stobo, having to rethink the issue of how to pay for the cost of educating Texas physicians may not be such a negative thing. "I think over the next 3 to 4 years, institutions like ours are going to be forced to examine what they're all about and reshape the way they carry out their academic missions." ★

East Coast, West Coast, Third Coast

Misery loves company, and it's good to know that Texas isn't alone in facing workforce challenges. Earlier this year, the Center for Health Workforce Studies at the School of Public Health at the University at Albany, State University of New York in Rensselaer, prepared a study comparing physician workforce issues among Texas, New York, and California, using data mostly from 1997. As you can imagine, the analysis is complex. The country's three biggest states are as similar as they are different.

When comparing the three, it's important to remember that California has a significantly higher population count — about 32.2 million, compared with Texas (19.4 million) and New York (18.1 million). It's also important to note that populations in Texas and California are growing at about the same rate, while New York's remains relatively stable. Taking population size and growth into account, the study shows that none of the states need to increase the number of physicians they must train in the coming years. It did note that Texas seemed to have a relatively limited medical education system, but countered that with Texas' large in-migration of physicians from out of state.

In New York, for example, the ratio of practicing physicians to population count in 1996 was an extraordinary 255.5 per 100,000. The state is considered a national and worldwide training ground for doctors, training about 15% of the nation's medical residents. And many of those trainees stay in the state, says the study. California's ratio of physicians to population in 1996 was considerably lower at 186.4 per 100,000. Despite its relatively limited medical education system, the state has a high retention rate and attracts physicians trained elsewhere. Texas, with a 1996 ratio of 147.9 physicians to 100,000 people, also has a limited medical education and training system on a per capita basis, but the number of practicing physicians in the state continues to grow because of in-migration.

The biggest difference among them is the approach to medical education and training. According to the study, 1997 Texas public medical school enrollment per capita was greater than the per capita public medical school enrollment of New York and California combined. But New York's nine private medical schools dominate its system. California's ratio of medical students to population is dwindling, but a recently opened osteopathic medical school is steadying that decline. The states are similar in overall enrollment, however, in that all three have far fewer minorities enrolled in medical school, in residency training, and in actual practice compared with the population.

Between 1988 and 1997, all three states experienced growth in the number of residents, but on a per capita basis, the ratio for New York, at 81.8 residents per 100,000 people, is about three times the ratio for California and Texas. This difference among New York, Texas, and California occurs in most specialties as well. Also notable, New York trained 7,523 international medical graduates (IMGs) in 1997, almost 1,500 more total residents than Texas has, and 3.5 times the number of IMG residents in Texas and California combined.

While Texas continues to grow in the ratio of primary care physicians to population, its numbers were below both New York and California.

While Texas continues to grow in the ratio of primary care physicians to population, its numbers were below both New York and California. In 1996, the ratio was 57.7 per 100,000 in Texas, 72 per 100,000 in California, and 89.8 per 100,000 in New York. Texas, however, had the highest proportion of primary care physicians (39%) of the three states. Texas also stands apart from New York and California when the ratio is broken down by county. For Texas, 77% of its counties have fewer than 100 physicians per 100,000 people. In New York and California, that number is about 30%. Compared with the other two states, however, Texas has a higher percentage of underrepresented minorities in its physician workforce.

According to the study, New York trains significantly more physicians than it needs, which accounts for its high physician-to-population ratio. However, New York sends a number of physicians to the rest of the country and the world, with California receiving about 14% of its physicians and Texas receiving about 9% of its physicians from the eastern state in 1997. While California actually trains fewer doctors than it needs, it is able to maintain a good physician-to-population ratio because of its high in-migration and retention rates. Texas also takes into account the large in-migration rates when determining how many physicians it must train, allowing it to maintain its balanced ratio of physicians to population.

Closing the loophole

Federal court rulings are narrowing the ERISA gap protecting HMOs from liability

How many times do stories like this have to be told? Alleged negligence by a health maintenance organization (HMO) leads to harm or injury to a patient, and that patient is told the HMO is not liable. As HMOs continue to plead to courts for protection under what lawmakers across the country believe is an outdated law, more and more federal judges are knocking negligence lawsuits against HMOs back down to the state level, where they can be tried and where HMOs can be held liable. ➤➤

By Monica Maldonado, Associate editor

The trend signifies a growing acceptance among lawmakers that the federal Employment Retirement Income Security Act of 1974 (ERISA) contains a loophole through which HMOs have been shirking liability. As many as 30 states are debating whether to give consumers the right to sue their HMOs for damages.

In 1997, Texas became the first to do something about the loophole. That year, the legislature passed the Texas Health Care Liability Act (Senate Bill 386), which allows an individual to sue a managed care entity for damages caused by its failure to exercise ordinary care when making a health treatment decision. Predictably, a group of insurance companies, led by Aetna US Healthcare, challenged that law by seeking a declaration that ERISA preempts its provisions. The group also sought to enjoin enforcement of the act. At press time, a federal district judge had overturned parts of the act she found to be preempted by ERISA. But in the meantime, federal circuit court judges have taken the matter into their own hands, establishing new precedents for trying HMO liability cases.

Conflict or complete?

One such case offers new hope for those who want to see the 1997 Texas law upheld. The story began in 1996, before the Texas law was put to paper, when 9-year-old Alex Giles, son of Bridgett Giles, of Houston, died after his doctors allegedly failed to diagnose an enlarged heart. Ms Giles sued NYLCare (her HMO), two physicians, and OneCare, a medical group that employed one of the two doctors. She sued in state court for negligence, vicarious liability, breach of contract, misrepresentation, and breach of warranty. NYLCare, however, sought to have the case moved to federal court on the grounds that her charges were preempted by ERISA.

Though originally set up to protect nongovernment employees with employer-sponsored insurance and retirement plans, ERISA has been interpreted by courts to prohibit people from availing themselves of state consumer protection laws. Charges such as wrongful death and personal injury, which fall under state jurisdiction, are preempted by ERISA, thus protecting HMOs and other insurers that make cost-cutting decisions that adversely affect patient care from damages. When an HMO is found guilty of a federal ERISA grievance, it pays only the cost of the procedure it denied in the first place, not any other damages available under state law.

Knowing her suit would be dismissed under the ERISA preemption, Ms Giles amended her charges, dropping all but the negligence and vicarious liability, and moving for a remand to state court. NYLCare appealed a lower court judge's ruling sending the case back to the state, but in April, the three-judge US 5th Circuit Court of Appeals upheld the original ruling. Its decision was based on what many legal experts call a difficult legal concept.

A multisectioned clause in ERISA — Section 514 — provides that all state laws, as they *relate to* any employee benefit plan, are *superseded* by ERISA. The words "relate to" are the key words that have led to the majority of ERISA case law on preemption. Courts have been interpreting the "relate to" clause literally, which has resulted in these cases being tried at the federal level and, therefore, falling prey to ERISA preemption. An exception to that clause is the issue of "conflict preemption."

In a 1998 paper presented by attorneys Gary Howell, JD, and Natalie Cadavid, JD, for the American Medical Association, the authors wrote: "'Conflict preemption' will be present wherever there is a contention that application of state law 'relates to' an ERISA plan. The crux is whether the relief that is being sought can be characterized as only available under ERISA. If so, then the procedural doctrine of 'complete' preemption will apply and the case will be heard in federal court. If not, the state law claims may be made, and preemption (i.e. 'conflict preemption') will be argued as a defense against application of state law."

This means that if a federal court determines that the doctrine of "complete" preemption does not apply but that there is still the question — as in the Giles case — of whether the state law relates to an ERISA plan, then the federal court may remand the case to state court. The defendant — in this case, NYLCare — can argue its case there.

When an HMO is found guilty of a federal ERISA grievance, it pays only the cost of the procedure it denied in the first place, but no other damages or penalties.

The 5th Circuit Court decided that because Ms Giles amended her complaint to eliminate completely preempted claims, "only arguably conflict-preempted claims remain." It continued, "Ms Giles has brought state common law causes of action that, in their application, relate to the regulation of health care — *an area of traditional state regulation.* NYLCare does raise a federal law defense of ERISA preemption. But state courts, being of equal dignity with federal courts, are equally competent to address that potential defense," he said.

"The key point of this case is that it is the first time the 5th Circuit has allowed a quality-of-care claim to go forward in a state court," said George Parker Young, JD, Ms Giles' attorney. "In the past, it has almost consistently adopted ERISA." He added that he doesn't think NYLCare's conflict preemption argument is going to stick in state court once it comes to trial. "I believe Ms Giles' claims are not preempted," said Mr Young. "We'll see if

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the judge agrees with me. And the 5th Circuit Court gives a strong hint that the judge will agree with me because in the body of his opinion he calls these 'traditional state regulations.'"

A nationwide trend

Other federal court rulings have sent similar cases back to their respective states. In a recent case, the US Supreme Court remanded a case to a California state court, saying that ERISA should not preempt state laws that, by common sense, apply to insurance companies. In the case of *Unum Life Insurance Co v John E. Ward,* a man filed a claim for disability well after his insurance company's 18-month deadline, yet his attorney argued that his claim was valid because a state law prohibits an insurer from denying a claim on the basis of lateness unless the insurer can prove it was prejudiced by the delay. The Supreme Court upheld the ruling of a lower court that ERISA should not preempt the state law in this case.

The court wrote that the three requirements under ERISA's savings clause (a subsection of Section 514) "are considerations to be weighed . . . and none is determinative in itself." Under this clause, the state law is preempted by ERISA if it relates to an ERISA plan unless it "regulates insurance," a measure tacked on to ERISA that aims to preserve states' right to regulate "the business of insurance." To be considered "the business of insurance," a practice must do three things: spread or transfer a policyholder's risk, be an integral part of a policy relationship between the carrier and the insured, and be limited to legal entities within the insurance industry. In the past, courts have determined the clause's applicability based on whether the practice met all three requirements. The court's ruling in essence relaxes the precedent that all three should be considered.

Many believe the Supreme Court's decision will allow states more room in introducing laws that focus on regulating health insurance. Harold Freeman, TMA's assistant director of legislative affairs, says this is another example of the narrowing of the ERISA loophole.

Room for the Texas law

Mr Young believes the Giles case will affect the final decision on Aetna's appeal of a US District Court's 1998 decision on the Texas Health Care Liability Act. In that case, Aetna sought a declaration that the act was preempted by ERISA and the Federal Employees Health Benefit Act (FEHBA). The Texas Department of Insurance wanted the Aetna appeal dismissed, arguing that the act seeks to regulate the "quality" of care an HMO provides, not how HMOs make benefit or coverage determinations — a matter the law leaves to the federal government.

Then Aetna pulled out the "relates to" clause, claiming the act applies to ERISA plans. The US District Court ruled that the act could be cut, removing those portions it deemed to fall under the ERISA preemption, while leaving the rest of the statute in place. As a result of this ruling, a plaintiff could challenge the quality of benefits received without challenging the denial of benefits or the way the HMO handled a medical claim — still leaving gray area but leaving the interpretation of that area to the state. According to Mr Young, who is also an attorney representing the state in Aetna's appeal of this ruling, oral arguments in the case will be heard in the fall of 2000.

But he is optimistic about the state's eventual decision in this case. "I think the Giles case does send a good signal, but it may not be outcome determinative," Mr Young said. "It is going to be helpful, though."

TMA's General Counsel Donald P. Wilcox, JD, is also optimistic. "The Giles decision, coming from the 5th Circuit, is a sign that the state of Texas has a good chance of successfully defending the TMA-supported Health Care Liability Act." The AMA and TMA filed a joint amicus curiae brief at the 5th Circuit this spring in support of the legislation. Oral arguments of the Aetna appeal are expected to begin in the fall of 1999. ★

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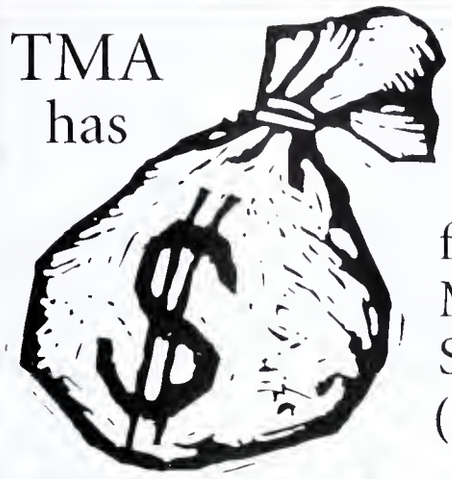

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Upping the ante

How might stricter HMO solvency requirements change the health care market?

Most health maintenance organizations (HMOs) in Texas have been losing money since 1996. The industry lost more than $333 million last year. Recognizing that Texas has had the most lax reserve requirements of any state for HMOs, state officials are playing catch-up.

According to a new Texas Department of Insurance (TDI) report that evaluated the 1998 financial performances of licensed HMOs, 37 of the state's 50 basic service HMOs lost money last year. One small HMO headquartered in San Antonio, WellChoice, recently went belly-up, stranding more than 20,000 patients (see "Standing on Shaky Ground," May 1999 *Texas Medicine*, pp 32–34). At least one other is precariously close to insolvency.

Although they're an overdue necessity, stricter solvency requirements likely will hasten the state's evolution toward managed care market "maturity," as experts call it. Market maturity doesn't just mean HMO saturation, where almost everyone is enrolled in an HMO. It usually also means that most of those enrollees are divided among a few large companies.

Catching up

Texas has been behind the curve in regulating the HMO industry, partly because the HMO is a whole different kind of health insurance animal and partly because the industry grew quickly after it burst onto the scene. Technically, HMOs are not insurance companies; therefore, a whole new set of laws had to be fashioned to regulate them. Unfortunately, those laws omitted some basic protections. Like insurance companies, HMOs engage in ventures that involve risk. But unlike insurance companies, they haven't been required to keep much money in reserves. Now, Texas is rectifying that situation by applying basic insurance safeguards to HMOs.

During its recently concluded session, the Texas Legislature passed a bill that would apply higher standards to HMOs. At press time, the bill was awaiting the expected signature of Gov George W. Bush. Scott McClellan, Governor Bush's spokesperson, said the governor supports the bill "because it protects consumers by ensuring that HMOs are financially

By Teri Moran, Senior editor

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sound." HMOs have until December 31, 2002, to put the changes into effect.

The net worth requirement portion of the bill says HMOs must calculate the true level of their liabilities and also maintain assets to cover them. In traditional insurance, the actual amount of liability a company carries must be shown on its books, and it must maintain assets against them. That isn't the case with HMOs. For instance, if an HMO has $7 million in assets and subtracts $5 million in liabilities, its net worth is said to be $2 million. But what if $3 million of the $5 million in liabilities is what an HMO pays in capitated contracts to providers and hospitals? The actual liability, or risk, of that $3 million could be closer to $5 million.

HMOs can show a positive net worth in such cases because they haven't been required to represent in their accounting the true cost of carrying that risk. Now, they'll not only have to account for those liabilities in their balance sheets, but they'll also have to set aside $1.5 million to cover them. The bill also says TDI can tell HMOs to set aside more than that if necessary.

"Under past legal requirements, HMOs didn't have to count as a liability the risk they transferred to hospitals and providers," said Texas Commissioner of Insurance José Montemayor. "It would be possible for an HMO to look financially healthy even if it wasn't."

The bill's other significant provision is an increase in the amount HMOs must put into capital reserves relative to the amount of risk they assume. Before the law, when calculating how much money they were required to hold in a reserve fund, HMOs didn't have to take into account the number of enrollees they covered or the dollar amount of all the risk they were assuming. This particular change is less a response to how much money HMOs have been losing lately than it is just the sensible thing to do.

"Basically, we're asking HMOs to show us the money," Mr Montemayor said.

Mom, dad, please send me a check

If many Texas HMOs didn't have corporate parents bailing them out, their bot-

tom lines would look much worse. Mr Montemayor says some corporate parents send money to their "babies" on a quarterly basis. Large corporations are willing to sink lots of money into an emerging market to gain market share.

According to Jerry Patterson, who heads the Texas Association of Health Plans, that's often just the cost of doing business. "Some HMOs have priced very close to the margin for market penetration, and that's not a bad decision, particularly if they've got the financial wherewithal to accept the marginal financial performance that results."

And losing money in a year doesn't mean you have a financially insolvent HMO, Mr Patterson says. "That distinction needs to be made. An HMO that loses money is not necessarily bad. But an HMO that's broke *is* bad."

Last year, TDI asked HMOs to pony up money to cover losses they purposely incur by underpricing their products. Cutthroat competition has motivated them to charge premiums that don't even cover costs. "It's like having two bags of sugar," Mr Montemayor said. "One costs $1 and one costs $1.50. Which one will you buy? Well, employers see very little distinction between HMOs, so they choose the one that costs less."

Rising health care costs nationwide have forced employers to get as much as possible for their dollars. Health care premiums are rising 7.5% on average in 1999, about quadruple the rate of inflation, according to a Watson Wyatt study conducted in conjunction with the Washington Business Group on Health.

But Texas HMOs haven't followed the national trend to raise premiums, and parent company subsidization has kept many in the game. The lack of subsidization also has caused some to struggle, others to fold. A case in point is WellChoice, which TDI placed in receivership earlier this year. Its corporate parent refused to bail out WellChoice, and it went under.

Toward market maturity

Already the biggest corporate players share between them the bulk of the country's HMO-enrollee pie. A recent report shows that four HMOs now cover 28.8 million enrollees, or almost 30% of all HMO-covered lives in the country. Kaiser Permanente tops the list, followed by United HealthCare, Aetna US Healthcare, and CIGNA HealthCare, according to the Scott-Levin report. Recent high-level mergers have narrowed the number of the nation's corporate HMOs since 1995 from 20 to 13.

With the costs of technological advances, new and expensive prescription drugs, and an aging population, consolidation has become a key for survival in the health care market. And with Texas imposing higher financial standards on HMOs, it's possible only the big guys will be left standing.

Mr Patterson believes consolidation and mergers can be a good thing. "There are economies of scale that result from mergers and acquisitions that affect the bottom line in a positive manner. I think we'll see more of those." Mr Patterson says the market in Texas may eventually have two or three "biggies," five or six moderately sized plans, and fewer of the small-niche plans. As a result, he says, there will still be consumer choice, but not consumer confusion.

Mr Montemayor says the new financial standards may indeed kick smaller plans out of the market, especially those that have been financially irresponsible. Other plans may merge or sell. He says the new TDI standards will protect consumers. "We want consumers and health care providers to feel secure about their health plans." ★

"There are economies of scale that result from mergers and acquisitions that affect the bottom line in a positive manner. I think we'll see more of those."

TEXAS MEDICAL ASSOCIATION
STROKE
PROJECT

Striving to reduce morbidity and mortality as a result of stroke.

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- CATEGORY 1 OF THE PHYSICIAN'S RECOGNITION AWARD OF THE AMERICAN MEDICAL ASSOCIATION
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The Texas Medical Association Stroke Prevention Project is a joint project of TMA and the American Heart Association, Texas Affiliate, Inc, and is endorsed by the Texas Department of Health. Seminars are sponsored in part by an unrestricted educational grant from DuPont Pharma through the TMA Foundation.

HMO enrollment in Texas

	1997 Enrollment No. (%)	1997 Rank	1998 Enrollment No. (%)	1998 Rank
Prudential	422,586 (13.19)	2	509,902 (13.53)	1
Humana/PCA	433,004 (13.51)	1	439,145 (11.65)	2
NYLCare of the Gulf Coast	384,576 (12.00)	3	409,560 (10.86)	3
Harris Methodist	283,396 (8.84)	4	307,842 (8.17)	4
United	236,322 (7.37)	5	301,144 (7.99)	5
NYLCare of the Southwest	174,574 (5.45)	7	204,442 (5.42)	6
PacifiCare	197,002 (6.15)	6	188,997 (5.01)	7
Rio Grande	115,850 (3.61)	10	163,514 (4.34)	8
Scott & White	142,451 (4.44)	8	142,330 (3.78)	9
Texas HealthChoice	17,711 (0.55)	21	135,097 (3.58)	10
Aetna US Healthcare	63,603 (1.98)	14	122,623 (3.25)	11
Aetna US Healthcare of North Texas	93,439 (2.92)	12	114,309 (3.03)	12
SHA	102,345 (3.19)	11	105,936 (2.81)	13
CIGNA	71,525 (2.23)	13	90,917 (2.41)	14
Memorial Sisters of Charity	19,522 (0.61)	20	82,316 (2.18)	15
Americaid	25,927 (0.81)	16	65,273 (1.73)	16
AmeriHealth HMO	4,215 (0.13)	37	36,793 (0.98)	17
Family HC Centers	—	47	36,181 (0.96)	18
Methodist Care	9,828 (0.31)	31	31,351 (0.83)	19
Community First	23,438 (0.73)	17	28,281 (0.75)	20
Texas Childrens Health Plan	12,058 (0.38)	30	26,935 (0.71)	21
One Health Plan	15,459 (0.48)	25	23,519 (0.62)	22
West Texas Health Plans	21,476 (0.67)	18	23,152 (0.61)	23
Certus Healthcare	9,158 (0.29)	32	22,359 (0.59)	24
Mid-Con Health Plans	15,815 (0.49)	24	19,772 (0.52)	25
HealthFirst HMO	12,148 (0.38)	29	19,730 (0.52)	26
Community Health Choice	12,438 (0.39)	27	19,503 (0.52)	27
Vista Health Plan	12,981 (0.41)	26	15,189 (0.40)	28
Healthplan of Texas	8,731 (0.27)	33	10,957 (0.29)	29
Foundation Health	20,491 (0.64)	19	10,827 (0.29)	30
Presbyterian Health Plan	12,171 (0.38)	28	10,616 (0.28)	31
Seton Health Plan	7,577 (0.24)	34	9,489 (0.25)	32
Exclusive Healthcare	16,998 (0.53)	22	8,986 (0.24)	33
Parkland Community Health Plan	—	46	8,836 (0.23)	34
Mercy Health Plans of Missouri	5,383 (0.17)	36	6,530 (0.17)	35
Amil	1,988 (0.06)	39	6,410 (0.17)	36
Valley Baptist Health Plan	—	43	5,119 (0.14)	37
Unicare	1,081 (0.03)	40	2,620 (0.07)	38
Anthem Health Plan	4,141 (0.13)	38	1,391 (0.04)	39
Universal Healthplan	—	44	1,152 (0.03)	40
Texas Universities Health Plan	—	45	531 (0.01)	41
Physicians Care HMO	124 —	41	208 (0.01)	42
Principal	38,992 (1.22)	15	—	43
Kaiser Foundation Health Plan	130,690 (4.08)	9	—	44
Healthsource North Texas	16,356 (0.51)	23	—	45
FHP of New Mexico	—	42	—	46
Comprehensive Health Services	7,428 (0.23)	35	—	47
Total	3,204,998 (100.0)		3,769,784 (100.0)	

Source: Texas Department of Insurance

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Searching for preventable causes of child mortality in Texas: trends in the major causes from 1987 through 1996

GEORGE R. KERR, MD
DAVID J. RAMSEY, PHD
WILLIAM SPEARS, PHD

We ranked the underlying causes of child deaths in Texas from 1989 through 1991 for the groups aged 1 through 4, 5 through 9, 10 through 14, and 15 through 19 years. External causes (injuries) accounted for 66% of child deaths, and 5 accounted for at least 100 deaths each: motor vehicle accidents, homicide, suicide, drowning, and burns. Of the deaths that had potential for primary prevention, more than 95% involved accidents, suicide, and homicide. Of the smaller number of deaths that had potential for secondary prevention, treatment of infectious conditions had the greatest potential.

From 1987 through 1996, child deaths from all causes averaged 2498 per year. Natural causes averaged 871 per year; external causes averaged 1627 per year. Among the external causes, annual averages for accidents were 1089 deaths; for motor vehicle accidents, 703; for homicide, 334; and for suicide, 187.

We used linear regression analyses to estimate trends in deaths and mortality rates. The only categories that experienced an increased number of deaths, despite a 12% increase in the population, were deaths from all causes in the adolescent age groups; from natural causes in all but the group aged 1 through 4 years; from external causes in the adolescent age groups; from suicide in all but the group aged 1 through 4 years; and from homicide in all age groups. The increased number of deaths was often lower than the increase in the population, resulting in lower mortality rates. The only mortality rates that increased were those from all causes in the group aged 15 through 19 years; from natural causes, in both adolescent age groups; from suicide, in the group aged 10 through 14 years; and from homicide, in all but the group aged 5 through 9 years.

These trends suggest that primary prevention of child deaths in Texas should focus on external causes, particularly motor vehicle accidents, homicides, and suicides.

INTRODUCTION

National Health Objectives for the Year 2000 (1) include more than 100 strategies for reducing the morbidity and mortality of children. These objectives might be reached via the reductions that often accompany societal development (2), but accelerating their achievement by some planned intervention requires setting priorities for the causes to be reduced and the methods to be used.

The International Classification of Diseases (ICD) lists 800 natural (disease) causes, many with decimal subcodes, and a supplemental E code classification (E800–E999) for external causes such as accidents, homicide, and suicide (3). In attempting to identify and prioritize causes of childhood mortality that offer realistic targets for prevention, we examined the underlying causes of all childhood deaths in Texas from 1989 through 1991 and trends in the major causes from 1987 through 1996.

METHODS

The major causes of infant mortality in Texas that offer potential for either primary or secondary prevention already have been reported (4). But the causes of death change markedly after infancy, and this report deals with the underlying causes of death of Texas children aged 1 through 4, 5 through 9, 10 through 14, and 15 through 19 years.

The Bureau of Vital Statistics (BVS), Texas Department of Health, provided us with computer tapes listing the ICD codes for the underlying cause of each childhood death that occurred in Texas from 1989 through 1991. Deaths for each ICD code were totaled, and mean yearly mortality rates were calculated for each age group, per 100,000 population of that age in the 1990 census (5). We considered any ICD code that averaged at least 5 deaths per year to be a major cause. Each cause of death was considered with regard to its potential for either primary prevention (preventing the underlying cause) or secondary prevention (preventing the death by treating the underlying cause). We assumed that deaths from congenital abnormalities, viral and fungal infections, malignancies, and conditions such as hepatic coma and cystic fibrosis were not preventable, even though some might be treatable under certain conditions. We also identified the number of death certificates that listed ICD codes with a ".9" suffix, such as 799.9 (other unknown and unspecified causes), which precluded any speculation on their potential for prevention.

To calculate trends in the major causes of mortality, we used the reports on underlying causes of mortality prepared by the BVS, and the population estimates prepared by the Department of Rural Sociology, Texas A&M University. To blunt the effect of yearly variation in deaths from specific causes, linear regressions were calculated for deaths and mortality rates from 1987 through 1996.

RESULTS

Results are presented in Tables 1 through 7. The codes shown in Tables 1 through 4 reflect averages of at least 5 deaths per year.

Major causes of death of children aged 1 through 4 years, 1989 through 1991

Of a total of 1772 deaths in Texas from 391 individual ICD codes, 23 codes accounted for roughly half of the total (Table 1). Injuries accounted for 44% of

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all deaths. Potential existed for primary prevention of 45.9% of the total deaths, with injuries accounting for 95% and the remainder representing a few cases of human immunodeficiency virus (HIV) infection, measles, and neural tube defects. Potential existed also for secondary prevention of 10.8% of the total deaths by treating the underlying causes — bacterial infections, asthma, bronchitis, metabolic and seizure disorders, and surgical conditions such as Meckel's diverticulum and intussusception.

Major causes of death of children aged 5 through 9 years, 1989 through 1991
Of the 997 deaths from 247 individual ICD codes, 12 codes accounted for 43% of the total deaths (Table 2). Injuries accounted for 49% of all deaths. Potential existed for primary prevention of 51% of the total deaths, with injuries accounting for 97% and the remainder representing a few cases of HIV infection, congenital syphilis, spina bifida, and protein-calorie malnutrition. Potential existed also for secondary prevention of 7.2% of the total deaths by treating the underlying causes, especially bacterial infections.

Major causes of death of children aged 10 through 14 years, 1989 through 1991
Of the 1107 deaths from 286 individual ICD codes, 14 codes accounted for 43% of the total deaths (Table 3). Injuries accounted for 53% of all deaths. Potential existed for primary prevention of 53.2% of the total deaths, with injuries accounting for 98.8% and the remainder representing a few cases of HIV infections and spina bifida. Potential existed also for secondary prevention of 6.8% of the total deaths by treating the underlying causes, especially bacterial infections.

Major causes of death of children aged 15 through 19 years, 1989 through 1991
Of the 3769 deaths from 419 individual ICD codes, 37 codes accounted for 75% of the total deaths (Table 4). Injuries accounted for 83% of all deaths. Potential existed for primary prevention of 83.4% of total deaths, with injuries accounting for 99% and the remainder representing a few deaths from HIV infection, substance abuse, and measles. Potential existed also for secondary prevention of 1.5% of the total deaths by treating the underlying causes, especially bacterial infections.

Table 1. Major causes of mortality of Texas children aged 1 through 4 years, 1989 through 1991.

ICD*	Cause	Deaths/3 Years
1. **E910.8**	**Other accidental drowning**	97
2. **E814.7**	**MVA;† pedestrian**	93
3. **E890.2**	**Other fire/smoke causes**	82
4. **E812.1**	**MVA; collision with MV**	78
5. 746.9	Unspecified anomaly of heart	56
6. **E822.7**	**MVA; collision; moving object**	41
7. **E910.9**	**Accidental drowning, unspecified**	39
8. **E968.9**	**Assault, unspecified means**	36
9. 799.9	Other unknown, unspecified cause	29
10. 194.0	Malignant neoplasm, adrenal	28
11. 343.9	Unspecified cerebral palsy	26
12. 486	Pneumonia, unspecified cause	25
13. 485	Bronchopneumonia, unspecified cause	22
14. **E816.1**	**MVA; loss of control**	21
15. **E910.4**	**Accidental drowning, bathtub**	21
16. 770.7	Chronic respiratory; perinatal	20
17. **E890.3**	**Burns**	20
18. 204.0	Acute lymphoid leukemia	19
19. **E911**	**Suffocation/choking; food**	19
20. 38.9	Unspecified septicemia	18
21. 191.9	Malignant neoplasm, brain	15
22. 427.5	Cardiac arrest	15
23. **E967.9**	**Battering, unspecified person**	15
Deaths/3 years, 23 major causes		835
% total deaths/3 years		47.1
TOTAL deaths, all 391 causes		1772
TOTAL mortality rate, all 391 causes		52.5‡
Deaths with primary prevention potential		**814**
Deaths from injury (E-code deaths)		**773**
Deaths with secondary prevention potential		**192**
Deaths from bacterial infections		**128**

* International Classification of Disease code; E-code causes of death are indicated by bold type.
† MVA = motor vehicle accidents
‡ Yearly average, per 100,000 in the 1990 Census.

Deaths from external causes, Texas children, 1989 through 1991
Table 5 summarizes the 5039 child deaths attributed to external causes from 1989 through 1991. These accounted for 66% of all deaths, rising progressively with age, and more than 80% of the deaths of children aged 15 through 19 years. Of the various causes of death, 5 categories (motor vehicle accidents, homicide, suicide, drowning, and burns) each accounted for

Table 2. Major causes of mortality of Texas children aged 5 through 9 years, 1989 through 1991.

ICD*	Cause	Deaths/3 Years
1. **E814.7**	**MVA;† pedestrian**	80
2. **E812.1**	**Other MVA; collision with MV**	63
3. **E890.2**	**Other fire, smoke**	51
4. **E910.8**	**Other accidental drowning**	48
5. 191.9	Malignant neoplasm, brain	32
6. 343.9	Unspecified cerebral palsy	29
7. 204.0	Acute lymphoid leukemia	27
8. **E813.6**	**MVA; collision; other vehicle**	23
9. 277.0	Cystic fibrosis	19
10. **E965.4**	**Assault; unspecified firearm**	19
11. **E910.2**	**Accidental drowning, recreation**	18
12. **E910.9**	**Accidental drowning, unspecified**	15
Deaths/3 years, 12 major causes		424
% total deaths/3 years		43.4
TOTAL deaths, all 247 causes		977
TOTAL mortality rate, all 247 causes		23.4‡
Deaths with primary prevention potential		498
Deaths from injury (E-code deaths)		483
Deaths with secondary prevention potential		70
Deaths from bacterial infections		31

* International Classification of Disease code; E-code causes of death are indicated by bold type.
† MVA = motor vehicle accidents
‡ Yearly average, per 100,000 in the 1990 Census.

more than 100 deaths during the 3-year period.

Motor vehicle accidents (E810–E825) accounted for 27.8% of total deaths and 42.1% of deaths from external causes. Homicide accounted for 13.4% of total deaths and 20.3% of deaths from external causes. Suicide accounted for 7.8% of total deaths and 11.8% of deaths from external causes. Drowning claimed 5.8% of the total and 8.8% of all deaths from external causes. Firearms were involved in 1366 deaths: 17.9% of all deaths, 27.1% of deaths from external causes, 69.7% of suicide deaths, 73.8% of homicide deaths, and 47.6% of deaths of undetermined intent.

Trends in deaths and mortality rates from all causes, Texas children, 1987 through 1996

During the decade from 1987 through 1996, the total number of child deaths averaged 2498 per year, with almost half in the group aged 15 through 19 years (Table 6). Linear regression estimated a reduction of 44 deaths per year over the decade, the net of 150 fewer deaths per year among children aged 1 through 4 years, 31 fewer deaths in those aged 5 through 9 years, and increases of 69 and 68 deaths per year in the groups aged 10 through 14 years and 15 through 19 years. The total population of children increased by 12.4%. Linear regression estimated an annual reduction of 7 deaths per 100,000 children over the decade, with reductions in all groups except the children aged 15 through 19 years (Table 7).

Trends in deaths and mortality rates from natural causes, Texas children, 1987 through 1996

Deaths from natural causes (ICD 001-799) averaged 871 per year (34.9%) of all deaths (Table 6). Linear regressions estimated an increase of 28 deaths per year over the decade. Table 7 shows linear regression estimates of reductions in the mortality rate over the decade for the younger age groups but increases for the groups from 10 through 19 years.

Trends in deaths and mortality rates from external causes, Texas children, 1987 through 1996

Deaths from external causes (ICD E800–E999) averaged 1627 (65.1%) per year of all deaths (Table 6). Linear regression estimated fewer deaths over the decade among the populations aged 1 through 9 years, and increases for those aged 10 through 19 years. Table 7 shows linear regression estimates of reductions in the mortality rates, with the largest being in children aged 1 through 4 years. Even though deaths increased in the populations aged 10 through 19 years, the rate of increase was less than that of the population growth.

Trends in deaths and mortality rates from accidents, Texas children, 1987 through 1996

Deaths from accidents (ECD E800–E949) averaged 1089 (43.58%) per year of all deaths. Linear regression estimated 284 fewer deaths per year over the decade (Table 6). Linear regression estimated reductions in deaths and in the mortality rate (Table 7) over the decade for all age groups.

Trends in mortality rates from some major causes of accident deaths, Texas children, 1987 through 1996

Table 6 shows deaths and linear regressions for burns and fire (E890–E899), drowning (E910), aspiration and suffocation from food and other items (E911–E915), and firearm missile acci-

dents (E922). The mortality rates from these causes all declined over the decade.

Trends in deaths and mortality rates from motor vehicle accidents, Texas children, 1987 through 1996

Child deaths from motor vehicle accidents (E810–E825) averaged 703, or 28.2%, per year of all deaths and 64.6% of all accident deaths (Table 6). Linear regressions estimated reductions in deaths of all groups except for a slight increase in deaths of children aged 10 through 14 years, and reductions in the mortality rates for all age groups.

Trends in deaths and mortality rates from suicide, Texas children, 1987 through 1996

Deaths from suicide (E950–E959) averaged 187 (7.5%) per year of all deaths (Table 6). The largest proportion (86.7%) was in the population aged 15 through 19 years, but 13% occurred among children aged 10 through 14 years. Linear regressions estimated an increase in suicide deaths over the decade in the groups aged 10 through 19 years. Linear regression for mortality rates (Table 7) estimated a slight reduction as the rate of increase was less than the rate of population growth, except in the group aged 10 through 14 years.

Trends in deaths and mortality rates from homicide, Texas children, 1987 through 1996

Deaths from homicide (E960–E969) averaged 334 (13.3%) per year of all deaths (Table 6). Linear regression estimated an increase in deaths over the decade for all age groups. Firearms and explosives were involved in 177 of the 208 homicide deaths in the population aged 15 through 19 years in 1996. Linear regression for homicide rates (Table 7) estimated an increase in all groups except for ages 5 through 9 years.

Table 3. Major causes of mortality of Texas children aged 10 through 14 years, 1989 through 1991.

ICD*	Cause	Deaths/3 Years
1. **E812.1**	**Other MVA;† collision with MV**	63
2. **E965.4**	**Assault; unspecified firearm**	61
3. E814.7	**MVA; pedestrian**	51
4. E922.9	**Accidental gunshot wound, NOS‡**	43
5. **E955.4**	**Suicide; unspecified firearm**	41
6. E813.6	**MVA; collision with MV**	35
7. **E816.3**	**MVA; loss of control**	33
8. E910.8	**Other accidental drowning**	33
9. 343.9	Unspecified cerebral palsy	26
10. 204.0	Acute lymphoid leukemia	25
11. 191.9	Malignant neoplasm, brain	18
12. 493.9	Asthma; unspecified	17
13. **E910.2**	**Accidental drowning, recreation**	16
14. 746.9	Unspecified congenital anomaly; heart	15
Deaths/3 years, 14 major causes		477
% total deaths/3 years		43.1
TOTAL deaths, all 286 causes		1107
TOTAL mortality rate, all 286 causes		28.6 §
Deaths with primary prevention potential		**589**
Deaths from injury (E-code deaths)		**582**
Deaths with secondary prevention potential		**75**
Deaths from bacterial infections		**25**

* International Classification of Disease code; E-code causes of death are indicated by bold type.
† MVA = motor vehicle accidents
‡ NOS = not otherwise specified
§ Yearly average, per 100,000 in the 1990 Census.

DISCUSSION

Vital statistics reflect the number of deaths in relation to the size of the population. A lower mortality rate may reflect a lower incidence of the problem, fewer deaths, increased population growth, or some combination of the three. A higher mortality rate, concurrent with population growth, reflects increased deaths and usually indicates a priority public health issue. Mortality rates tend to decline with societal development, probably the result of population growth, and static or fewer deaths mediated by increased socioeconomic status, reduced environmental hazards, and increased ability to prevent and treat specific diseases.

The earliest vital statistics indicated that the major causes of death were infectious and contagious diseases (6,7). Only as these were prevented or treated did other causes of death, such as preterm birth, congenital abnormalities, and injuries, move up in the order of causes of child death.

In the United States, the first national data on causes of death in childhood were reported in the 7th census of 1850 (8). In ranked order, the causes of death of children aged 1 through 4 years were diarrhea and dysentery, scarlet fever, croup, "fever," whooping cough, pneumonia, cephalitis, and accidents. For children 5–9 years, the major causes were diarrhea and dysentery, scarlet fever, "fever," accidents, typhoid fever, croup, dropsy, cephalitis, pneumonia, and consumption. For children

Table 4. Major causes of mortality of Texas children aged 15 through19 years, 1989 through 1991.

ICD*	Cause	Deaths/3 Years
1. **E965.4**	**Assault; unspecified firearm**	576
2. **E955.4**	**Suicide; unspecified firearm**	303
3. **E812.0**	**Other MVA;† collision with MV (driver)**	214
4. **E815.0**	**Other MVA; collision, highway (driver)**	184
5. **E812.1**	**Other MVA; collision with MV (passenger)**	182
6. **E815.1**	**Other MVA; collision, highway (passenger)**	158
7. **E816.0**	**MVA; no collision**	143
8. **E814.7**	**MVA; collision; pedestrian**	104
9. **E953.0**	**Suicide; hanging**	90
10. **E816.1**	**MVA; loss of control**	88
11. **E922.9**	**Accidental firearm, shotgun**	79
12. **E966**	**Assault; cutting/piercing**	78
13. **E910.8**	**Other drowning**	69
14. **E965.1**	**Assault; shotgun**	53
15. **E812.2**	**Other MVA; collision with MV**	46
16. **E910.2**	**Accidental drowning, recreation**	44
17. **E819.9**	**MVA; unspecified**	43
18. **E955.1**	**Suicide; shotgun**	34
19. **204.0**	**Acute lymphoid leukemia**	28
20. **E815.2**	**Other MVA; collision, highway (motorcyclist)**	25
21. 359.1	Hereditary muscular dystrophy	24
22. **E963**	**Assault; hanging/strangulation**	21
23. 191.9	Malignant neoplasm; brain	20
24. 205.0	Acute myeloid leukemia	19
25. **E955.0**	**Suicide; handgun**	19
26. **E968.9**	**Assault; unspecified**	19
27. 343.9	Unspecified cerebral palsy	18
28. **E810.0**	**MVA; collision with train (driver)**	18
29. **E812.9**	**Other MVA; collision with MV**	17
30. **E813.6**	**MVA; collision; MV**	17
31. **E950.3**	**Suicide; tranquilizers**	17
32. **E985.4**	**Injury; unspecified firearm**	17
33. 799.9	Other unknown, unspecified	16
34. 425.4	Other primary cardiomyopathy	15
35. 493.9	Unspecified asthma	15
36. **E810.1**	**MVA; collision with train (passenger)**	15
37. **E816.9**	**MVA; loss of control**	15
Deaths/3 years, 37 major causes		2843
% total deaths/3 years		75.4
TOTAL deaths, all 419 causes		3769
TOTAL mortality rate, all 419 causes		95.5‡
Deaths with primary prevention potential		**3144**
Deaths from injury (E-code deaths)		**3113**
Deaths with secondary prevention potential		**55**
Deaths from bacterial infections		**19**

* International Classification of Disease code; E-code causes of death are indicated by bold type.
† MVA = motor vehicle accidents
‡ Yearly average, per 100,000 in the 1990 Census.

aged 10 through 19 years, the main causes were diarrhea and dysentery, consumption, typhoid fever, "fever," accidents, pneumonia, dropsy, cephalitis, and scarlet fever.

Between 1850 and 1900, mortality rates fell from 2395 to 1629 per 100,000 children aged 1 through 4 years; from 669 to 414 per 100,000 children aged 5 through 9 years; and from 528 to 400 per 100,000 children aged 10 through 19 years (9). Infectious diseases remained the major causes of death, but accidents and injuries were moving up in the ranking of causes.

By 1960, primary prevention of many contagious diseases had been accomplished through immunization, and secondary prevention through improved medical and surgical therapies had prevented many deaths (10). Between 1900 and 1960, mortality rates fell from 104 to 27 per 100,000 children aged 1 through 4 years; from 1629 to 109 per 100,000 children aged 5 through 9 years; and from 400 to 135 per 100,000 children aged 10 through 19 years. Accidents were the leading cause of death at all ages except infancy. And suicide and homicide had become increasingly important as causes of death in adolescence.

Between 1960 and 1990, childhood mortality rates continued to fall in the United States, with deaths either falling or rising at a slower rate than the growth rate of the population (11). In Texas, total childhood deaths fell from 10,212 to 4561 (mainly reflecting a reduction of deaths in infancy from 7214 to 2080) (12,13). Deaths of children aged 1 through 4 years fell also from 1240 to 511; of children aged 5 through 9 years, from 574 to 354; and of those aged 10 through 14 years, from 477 to 363. However, deaths of children aged 15 through 19 years rose from 707 to 1263.

Another value of vital statistics is the ability to prioritize specific causes of

death and disease for prevention. Several years ago (4), we examined the potential for prevention of deaths of Texas infants, concluding that, of the 2545 infant deaths that occurred during 1990, potential existed for primary prevention of at least some of 783 deaths:

- By having infants sleep in the supine position to prevent some deaths from sudden infant death syndrome;
- By administering Surfactant to prevent some deaths from respiratory complications of preterm birth;
- By administering paraconceptual folic acid to prevent some deaths from neural tube defects;
- By increased parental supervision to prevent some deaths from accidents and injury; and
- By optimal preventive practices to prevent some infant deaths from obstetric/neonatal causes.

Potential existed also for secondary prevention of at least some of 1127 infant deaths:

- By optimal therapy for neonatal conditions;
- By optimal antibiotic therapy for bacterial infections;
- By therapeutic Surfactant for respiratory complications of preterm birth; and
- By optimal therapeutic management of obstetric, medical, and surgical conditions.

The present study followed the same protocol. The main conclusion was that, after infancy, relatively few causes of mortality were open to primary prevention, and, as with national statistics (14,15), most of these involved external causes such as accidents, suicide, and homicide. Even fewer were open to secondary prevention, with treatment of infectious diseases offering the greatest potential.

Table 5. Child deaths from external causes, Texas, 1989 through 1991.

		Ages (Years)				
ICD: E-code	Causes	1-4	5-9	10-14	15-19	Total
Accidents (E800-E949)						
E800-807	Railway	3	2	3	14	22
E810-819	Motor vehicle accident	229	216	267	1345	2057
.0	Driver	1	3	22	565	591
.1	Passenger	125	100	95	460	780
.2	Motorcyclist	-	-	8	87	95
.3	Motorcyclist passenger	-	1	36	14	51
.6	Pedal cyclist	2	23	37	17	79
.7	Pedestrian	93	80	51	105	329
.5,.8,.9	Others, unspecified	8	9	18	97	132
E820-825	Motor vehicle, non-traffic	44	7	8	6	65
E826-829	Other road vehicle accident	3	3	6	3	15
E830-845	Water, air, space transport (except E830,832)	0	0	4	11	15
E850-869	Poisoning	13	1	7	57	78
E870-879	Medical misadventures	6	2	3	2	13
E880-888	Falls	14	4	4	21	43
E890-899,924,926	Burns	113	62	19	14	208
E900-909	Natural causes	8	9	7	6	30
E910, 830,832	Drownings	163	88	62	129	442
E911-913	Inhalation/suffocation	45	14	13	12	84
E914-929	Other accidents	35	41	74	154	304
	(with firearm missiles)	(4)	(17)	(55)	(102)	(178)
All accidents		676	449	477	1774	3376
Suicide (E950-959)		-	2	70	522	594
(with firearms)		(-)	(-)	(47)	(367)	(414)
Homicide (E960-969)		98	39	98	787	1022
(with firearms)		(14)	(20)	(74)	(646)	(754)
Legal intervention (E970-978)		-	-	-	5	5
Undetermined intent (E980-989)		9	1	7	25	42
(with firearms)		(-)	(-)	(3)	(17)	(20)
Total deaths from injury (E-codes)		783	491	652	3113	5039
Total deaths from all causes		1772	977	1107	3769	7625
Injury (E-code) deaths, % of total		44.2	50.3	58.9	82.6	66.1

Five categories accounted for more than 100 child deaths each from 1989 through 1991:

- Motor vehicle deaths (2122 deaths). We do not know what proportion of these "accidents" involved alcohol or other substance abuse, but national estimates suggest that as many as one third of adolescents involved in fatal crashes may be intoxicated (16). National estimates suggest also a high frequency of nonuse or misuse of safety belts (16).
- Homicide (1022 deaths). Firearms were involved in 73.8% of those

Table 6. Trends in deaths from major causes in Texas children, 1987 through 1996.

10-Year Average Deaths and Linear Regressions, 1987-1996*	Ages (Years)				
	1-4	5-9	10-14	15-19	All
All causes	566	330	368	1234	2498
Regression over decade	-150	-31	+69	+68	-44
Natural causes	308	168	157	238	871
Regression over decade	-78	+7	+54	+46	+28
External causes	258	162	211	906	1537
Regression over decade	-72	-37	+15	+22	-72
Accidents	222	147	151	569	1089
Regression over decade	-86	-41	-13	-145	-284
Fire					65
Regression over decade					-32
Drowning					139
Regression over decade					-41
Inhalation/suffocation					27
Regression over decade					-13
Firearm accidents					49
Regression over decade					-25
Motor vehicle accidents	87	81	88	447	703
Regression over decade	-20	-6	0	-106	-131
Suicide	0	1	24	162	187
Regression over decade	0	+0.3	+14	+6	+20
Homicide	32	15	33	254	334
Regression over decade	+12	+3	+12	+154	+180

* Regressions indicate change in numbers of deaths per year over the decade.

deaths (84% of teen homicides nationally) (16). The toll from firearm-associated homicides in African Americans aged 15 through 19 years (335 deaths over the 3-year period) reflects a particularly urgent public health problem.

- Suicide (594 deaths). In Texas, firearms were used in 69.7% of the suicides from 1989 through 1991 (compared with 67% of juvenile suicides nationally) (16).
- Drowning (442 deaths, mostly accidental drowning in swimming pools) and burns (208 deaths). The last 2 priority causes of childhood deaths are drowning and burns. Their reductions over the past decade suggest that preventive strategies should focus on the top 3 causes (motor vehicle, homicide, and suicide).

Analysis of the trends in major causes of mortality from 1987 through 1996 indicated that deaths from many causes have decreased, either through primary or secondary prevention. The only increases involved deaths from all causes in children aged 10 through 14 and 15 through 19 years; deaths from natural causes at all ages except 1 through 4 years; deaths from external causes in children aged 10 through 14 and 15 through 19 years; deaths from suicide in all but the group aged 1 through 4 years; and deaths from homicide in all age groups. Some of these increases were too small to have statistical significance.

For many causes, even if the numbers of deaths increased over the decade, the increase was lower than the population growth, and the only mortality rates that increased were those for all causes in the group aged 15 through 19 years; for natural causes in children aged 10 through 14 and 15 through 19 years; for suicide in children aged 10 through 14 years; and for homicide in all but the children aged 5 through 9 years. Many of these increases also were too small to have statistical significance. But the trends suggest priorities among child populations and causes of death to be considered for preventive strategies: those with the highest numbers of deaths and those for which the mortality rates are rising most rapidly.

The main concerns are clearly the external causes of death, which, even if the overall mortality rate is falling, average more than 1600 deaths each year; most of these deaths are at least theoretically preventable. Among the various external causes, deaths and mortality rates for accidents are decreasing in all age groups but still average more than 1000 deaths per year. Deaths and mortality rates for motor vehicle accidents also are decreasing in all age groups but average more than 700 deaths each year, indicating the most urgent need for both primary and secondary preventive strategies. Homicide deaths average 334 per year and are of particular concern because homicide is the only external cause of death in which deaths and mortality rates are

rising for most ages. Suicide deaths (187 deaths per year) must be an important target for primary prevention because they reflect adolescent despair over the future. And needing to be monitored closely in the future are the deaths from natural causes during adolescence because they are increasing faster than the population and can be targeted for secondary prevention by the health care system.

These types of analyses carry obvious limitations. To prove by vital statistics that *any* individual death could have been prevented is impossible. But vital statistics focus on types of deaths and, with sufficient numbers, we can reasonably conclude that at least *some* might be preventable. Another limitation involves the incomplete information on some death certificates: in 662 (15%) of the 4500 child deaths in 1996, the ICD code for the underlying cause on the death certificate ended in a ".9" suffix, meaning that neither cause nor preventive strategies could be determined. And of those 662 children, 331 (50%) did not have an autopsy. So, clearly, the provision of information on death certificates must be improved for vital statistics to identify potentially preventable child deaths. A limitation of linear aggression analysis is that it may mask the start of important trends. For example, deaths from motor vehicle accidents increased by 195 between 1995 and 1996, mostly in the group aged 15 through 19 years. Whether this increased mortality reflected the increased speed limit legislated for Texas in 1996 and whether it will continue to rise must be determined. And after a fairly steady rise of homicide deaths between 1987 and 1994 (from 170 to 416 deaths per year), a sharp decrease occurred from 416 deaths in 1994 to 379 in 1995, and to 288 deaths in 1996. Whether this gratifying trend will continue also will have to be determined.

Finally, age and gender differences in mortality rates from specific causes must be recognized in planning preventive strategies: for example, the mortality rate for all external causes of Texas adolescents aged 15 through 19 years in 1996 was 67.2 per 100,000 but varied from 26.6 per 100,000 in black females to 111.1 per 100,000 in Hispanic males. The rate for motor vehicle accident deaths was 34.5 per 100,000 but varied from 13.6 per 100,000 in Hispanic females to 53.6 per 100,000 Anglo males. And the overall rate for homicide deaths was 14.0 per 100,000 but varied from 3.2 per 100,000 white females to 50.9 per 100,000 black males (13). Such differences must be incorporated into the design of preventive strategies.

Table 7. Mortality rates from major causes in Texas children, 1987 through 1996.

10-Year Average Mortality Rates (MR) and Linear Regressions, 1987-1996*	Ages (Years)				
	1-4	5-9	10-14	15-19	All
MR from all causes	46.6	23.6	24.3	80.3	46.6
Regression over decade	-18.1	-6.5	-0.1	+1.0	-7.0
MR from natural causes	19.9	12.0	11.5	17.1	16.2
Regression over decade	- 9.5	-1.6	+1.8	+2.5	-1.6
MR from external causes	21.1	11.6	15.5	72.2	27.3
Regression over decade	-8.7	-4.8	-1.9	-2.7	-5.4
MR from accidents	18.3	10.5	11.2	40.7	18.8
Regression over decade	-9.3	-4.9	-3.1	-12.3	-11.5
MR from fire, all ages					1.21
Regression over decade					-0.8
MR from drowning, all ages					2.59
Regression over decade					-1.1
MR from inhalation/choking, all ages					0.50
Regression over decade					-0.3
MR from firearm missile accidents					0.94
Regression over decade					-0.6
MR motor vehicle accidents	7.1	5.8	6.5	32.1	13.4
Regression over decade	-2.5	-1.7	-1.2	-9.0	-4.3
MR from suicide	0	.05	1.8	11.7	3.5
Regression over decade	-	0	+0.6	-0.1	-0.1
MR from homicide	2.64	1.0	2.4	18.4	5.9
Regression over decade	+0.6	0	+0.4	+10.2	+2.8

*Average MRs indicate average yearly deaths/100,000 children over the 1987-1996 decade. Regressions indicate the net change in the mortality rate per 100,000 children over the decade.

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Legal issues associated with sexual activity between adults and minors in Texas: a review

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Recent research on adolescent mothers and the age of their sexual partners has stimulated discussion of whether legal action should be taken against adult men who engage in sexual intercourse with minors. A nonrandom poll that started as casual questions but extended over 6 months to 52 doctors initiated this review. It became apparent that the primary care physicians (pediatrics, family medicine, and internal medicine) had little, if any, understanding of some key legal facts in Texas associated with adolescent sexuality and pregnancy, especially when adult partners are involved. This article provides a legislative overview for practitioners in an attempt to clarify the law, remediate any deficiency of knowledge, and remind physicians of their role in reporting sexual abuse of minors.

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INTRODUCTION

Adolescent pregnancy has an impact on all segments of society, rural and urban, although the latter has been better documented. In spite of medical, social, and educational interventions targeted at US inner-city youth, teen pregnancy persists as an important social, health, and legal concern. Although the national birth rate among US teens aged 15 to 19 years has declined during the period 1992–1995 (1), the number of nonmarital births to teens quadrupled after 1960, and the number of marital teen births has declined substantially.

With welfare reform under way and the desire to reduce nonmarital births, state policymakers are evaluating the legality of the sexual relations between adult men and minors. Such steps have generated policy questions within the health care community in reporting such situations. The purpose of this paper is to provide an overview of contemporary research on teenage pregnancy, especially concerning age of consent and the age of the male partner. Attention will be focused on existing statutes by legal codes and their relationship to child abuse, sexual assault, and statutory rape.

NONCONSENSUAL SEX WITH MINORS

Until recent times, the issue of sexual assault of teenagers has been underreported. This may be due in part to society's conflicting attitudes concerning consent, sexual intercourse, and rape. Significant numbers of adolescents and children, however, are victims of sexual assault, often involving multiple encounters. Twenty-nine percent of all forcible rapes occurred when the victim was younger than 11 years, while another 32% occurred between the ages of 11 and 17 years. The Alan Guttmacher Institute (2) reports that young, sexually experienced teenagers are likely to have had involuntary sex. Seventy-four percent of women who had intercourse before age 14 years and 60% of those who had sex before age 15 years report having had sex involuntarily.

CONSENSUAL SEX WITH MINORS

Not all sexual encounters among adolescent girls, however, are coerced. Nevertheless, many of the fathers involved in teenage pregnancies are adults. Statistically, more adolescent women than teenage men become parents each year. While 18% of women aged 15 to 17 years who have had intercourse become pregnant each year, only about 4% of the fathers are teenagers (2). Moreover, of the men involved in pregnancies with women younger than 18 years, only 26% are estimated to have been that young themselves, 35% are aged 18–19 years, and 39% are at least aged 20 years. Notable age differences between partners raise concerns about how assertive adolescent girls can be in insisting that their partners use condoms to prevent pregnancy and disease.

TEXAS STATUTES

Concern over such age differences is finding its way into public policy and the legislative process that generates laws covering sexual exploitation. For example, the age of consent is set at 17 years, and sexual relations are discouraged between young adolescents and adults. However, if the older man supports the young mother and her biological parents, does it make the relationship acceptable? Does the appropriateness change if the parents give their active or passive consent for such liaisons? What is an appropriate age of consent?

In Texas, the potential answers to such questions are found in 2 different sets of laws that sometimes are contradictory and confusing. The first set of laws, the Texas Penal Code, legislates adult sexual conduct with minors involving potential prosecution for criminal activity (3). A second set of laws, the Texas Family Code, protects adolescents from child abuse and neglect (4). Child abuse includes sexual activity committed by an adult with a child under a specified age (5). Note that, unlike the Texas Penal Code, the Texas Family Code has a mandatory reporting requirement when a physician believes that an adult is having sexual intercourse with a child under a specified age (6).

Table 1. Offenses committed against a child.

Offenses	Classification	Applies to children who are not the spouse of the actor and are:	Defense
Indency with a child	Second-degree felony and/or third-degree felony	Younger than 17 years.	Actor was 3 or fewer years older and did not use force or threat.
Sexual assault	Second-degree felony	Younger than 17 years.	Actor was 3 or fewer years older and the victim 14 years or older.
Aggravated sexual assault	First-degree felony	Younger than 14 years.	The conduct consisted of medical care for the child and did not include any sexual contact.
Prohibited sexual conduct (incest)	Third-degree felony	Not specified in penal code.	Not specified in statute.

THE TEXAS PENAL CODE AND OFFENSES AGAINST A CHILD

In the Texas Penal Code, various conditions mitigate the severity of a criminal offense. First, the couple's marital status affects statute relevancy. For example, an adult male who has sexual intercourse with a teenager under a certain age may have committed indecency with a child, sexual assault of a child, aggravated sexual assault, and/or incest (6, note 8) (Table 1). A person also may have committed a second-degree felony and the offense of indecency with a child when he engages in sexual contact with a child younger than 17 years (7). However, if the child is a teenager married to the accused, no offense has occurred.

Second, the span of the age difference between partners is important also. For example, if the alleged offender was not more than 3 years older than his partner and did not use duress, his act may be defendable. On the other hand, if the accused is more than 3 years older than the partner, consent is no defense. If the accused is less than 3 years older than the victim and the victim is at least aged 14 years, his act may be defendable (7). Ignorance of the child's age is not a defense (8).

Third, legislative intent affects the variance in the law. Although the definition of sexual assault and aggravated sexual assault of a child prohibits sexual conduct between an adult and a child younger than 14 years, the consequence of each offense differs. By enacting a separate provision using age of a child as an aggravating factor, the legislature demonstrates its intent to punish more harshly those who sexually assault children younger than 14 years (9).

Fourth, consanguinity complicates the intent of the statutes and introduces the issue of incest. A person commits an act of incest, a third-degree felony, when he engages in sexual intercourse with a person he knows to be one of the following: his ancestor or descendant by blood or adoption; his stepchild or stepparent, while the marriage creating that relationship exists; his parent's brother or sister of the whole blood or half blood; his brother or sister of the whole or half blood or by adoption; or the child of his brother or sister of the whole or half blood or by adoption (10).

THE TEXAS FAMILY CODE AND CHILD ABUSE AND NEGLECT

The Texas Family Code, in an attempt to focus on the broad protection of children, may confuse practitioners. Under the Texas Family Code, any person independent of age can abuse or neglect children (11,12). Inappropriate sexual behavior, according to this code, is a form of child abuse (Table 2). Thus, any person who commits indecency with a child, sexual assault of a child, aggravated sexual assault of a child, and/or incest with a child has committed child abuse. The Texas Family Code states that a "child" is a person younger than 17 years (13), and that abuse includes sexual conduct harmful to a child's mental, emotional, or physical welfare, and compelling or encouraging the child to engage in sexual conduct (14). Therefore, an adult male who commits the foregoing criminal offenses against a female younger than 17 years has also committed child abuse.

Parents or practitioners, under these statutes, can unwittingly become party to the abuse. Under the Texas Family Code, any person who actively

Table 2. Child abuse offenses.

Acts Committed by the Parent	Classification	Applies to Children	Defense(s)
Injury to a child that causes serious bodily injury or bodily injury by omission or commission.	An offense under "serious bodily injury" is a first-degree felony when the conduct is intentional. When reckless by omission, it is a second-degree felony. An offense under "bodily injury by omission or commission" is a third-degree felony when it is intentional conduct. When reckless by omission, it is a state jail felony.	14 years or younger	Before the offense, actor notified child that he would no longer care for him or her and notified in writing the child's guardians or the Department of Protective and Regulatory Services that he would no longer care for the child. Written notification must contain the name and address of the actor, the name and address of the child, and the date that care was discontinued. Affirmative defense to prosecution: that actor was a victim of family violence committed by a person who is also charged with an offense against the child; that actor did not cause the condition of injury to child; and that actor did not reasonably believe that at the time of the omission that an effort to prevent the person also charged with the offense against the child would have an effect.
Neglect — an act or omission by a person placing a child in or failing to remove the child from a situation in which the child would be exposed to a substantial risk of sexual conduct harmful to the child.	No classifications under the Texas Family Code	Younger than 17 years	N/A
Abuse — includes the following acts or omissions by a parent: failure to make a reasonable effort to prevent sexual conduct harmful to child; or sexual conduct harmful to child's mental, emotional, or physical welfare.	Same as above	Same as above	N/A

or passively approves of a sexual relationship between a child younger than 17 years and an adult commits abuse by omission and neglect (15). Such a provision could apply readily to parents who do not object to sexual conduct between teenagers younger than 17 years and adult men. For instance, a parent can commit child abuse by failing to make a reasonable effort to prevent sexual conduct harmful to a child or by compelling or encouraging the child to engage in sexual conduct with an adult (15). Parental neglect can occur if the parent fails to remove a child from a situation in which the child would be exposed to a substantial risk of harmful sexual conduct (15). Based on the foregoing, to avoid committing an act of child abuse, a parent must make a reasonable effort to prevent a sexual relationship between a female aged 17 years or younger and an adult male (16,17). Such knowledge does not absolve a practitioner from reporting.

REPORTING CHILD ABUSE

A physician who has cause to believe that a child is being abused or neglected by any person must make a report to either the Texas Department of Protective and Regulatory Services (TDPRS) or to the local state or law enforcement agency (Table 3) (18). The report must be filed within 48 hours after the physician first suspects that the child has been or may be abused or neglected (19). *A physician commits a*

Table 3. A physician's duty to report child abuse.

Matters to Report	To Whom Should the Physician Report	Contents of Report	Immunity	Penalty for Failure to Report	Penalty for a False Report
Abuse or neglect by person responsible for child's care	Texas Department of Protective and Regulatory Services	Name and address of the child; Person responsible for care; Any other pertinent information	Immune from civil or criminal liability	Class B misdemeanor	Class B misdemeanor
Abuse or neglect by person who is not responsible for child's care, custody, or welfare	Local or state law enforcement agency	Same as above	Same as above	Same as above	Same as above

criminal offense, a Class B misdemeanor, if he has cause to believe that a child is being abused and fails to report to the appropriate authority (20).

Some interpretations of the Texas Family Code suggest that patient-client privilege may not hold up in court. The requirement to report child abuse applies even to a physician whose personal communications may be otherwise privileged (21). The identity of the person who reports child abuse is confidential and may be disclosed only upon a court order or to a law enforcement officer for the purpose of conducting a criminal investigation of the report (22). If the abuser was a person responsible for the child's care, custody, or welfare, then the physician must report the alleged abuse to TDPRS (23). However, if the abuser was not responsible for the care of the child, then the physician should report the alleged abuse to any local or state law enforcement agency (24).

A physician acting in good faith who assists in the investigation of alleged child abuse is immune from civil or criminal liability that might otherwise be incurred, but no immunity exists if the report is made in bad faith or with malicious intent. A first false report is a Class A misdemeanor; subsequent offenses can result in a state jail felony (25). The foregoing discussion makes clear that physicians must assume their mandated responsibility in reporting and investigating instances of suspected child abuse committed by adult men toward teenage females, especially in cases in which the adult male impregnates the teenager.

SUMMARY: THEORY VERSUS PRACTICE

While the need to protect minors from unwanted sexual advances is an appropriate role for physicians, the technical aspects of the Texas Family Code and the Texas Penal Code will continue to confuse the medical practitioner. For example, the use of the word "predator" that is defined as a man more than 3 years older than the girl is often unclear. Therefore, a predator may still be a teenager, although in reality this is not the usual case. Such technical aspects may serve as subtle deterrents to keep the physician from becoming involved.

However, the extent to which Texas prosecutors and TDPRS use the foregoing statutes to deter adults from engaging in sexual conduct with children appears to be changing. Past national reports suggest that law enforcement agencies historically had been either indifferent to the problem or had encountered difficulties in prosecuting the cases when the teenagers did not cooperate (26). Some states have renewed their interest in prosecuting men who commit sexual assault upon a child, independent of the teenager's consent or acquiescence, especially when a pregnancy results (26). Whether or not Texas prosecutors and TDPRS will follow the lead of such states and zealously use their own statutes to deter sexual conduct between adults and teenagers is unclear. Regardless of the action or inaction taken by Texas prosecutors or TDPRS, physicians must still comply with the reporting requirements. Moreover, as future legislative sessions may further clarify or amend these statutes, physicians should keep abreast of any changes that would affect their role in legally deterring sexual intercourse between adolescent girls and adult men.

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20. Tex. Family Code Ann. § 261.109.
21. Tex. Family Code Ann. § 261.101(c).
22. Tex. Family Code Ann. § 261.101(d).
23. Tex. Family Code Ann. § 261.103(2).
24. Tex. Family Code Ann. § 261.103(1).
25. Tex. Family Code Ann. § 261.107(a).
26. Navarro M. Teen-age girls and older men. *New York Times.* May 19, 1996.

INFORMATION FOR AUTHORS

Texas Medicine has two purposes: As a newsmagazine for physicians it informs readers about public health issues, legislation, medical economics, legal topics, science, medical education, news of the Texas Medical Association, and general news of the medical profession in Texas. In its Journal section, *Texas Medicine* publishes peer-reviewed, clinically useful scientific articles and other technical information.

Texas Medicine seeks high-quality, preferably Texas-specific, review articles or original observations of particular interest to the broad range of Texas physicians for its Journal section. They may deal with medical, public health, social, or economic issues related to the health and well-being of Texans.

Material for the Journal section of *Texas Medicine* may be sent to the Managing Editor, *Texas Medicine,* 401 W 15th St, Austin, TX 78701. It must be offered solely to this journal. Articles are screened for appropriateness for *Texas Medicine*. Those selected for peer review are reviewed by consultant specialists and an Editorial Committee, and accepted or rejected on the basis of individual merit, appropriateness, and the availability of other material. Reviews usually take 10 to 12 weeks. *Texas Medicine* reserves the right to reject up to press time any articles that may have been accepted for publication.

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Manuscripts should be typed double-spaced with ample margins. Three copies, including illustrations, should be submitted and the author should keep a copy.

Titles should include the words most suitable for indexing the article in "Index Medicus," should stress the main point, and should be brief.

Include a mailing address and telephone number for each author.

An introductory summary of 100–150 words is required.

Text should be narrative with complete sentences, few abbreviations, and logical subheadings. For spelling and usage the editors follow "Dorland's Illustrated Medical Dictionary," 26th edition, and "Webster's Third New International Dictionary, Unabridged."

The text of observational and experimental articles is usually — but not necessarily — divided into sections with the headings: Introduction, Methods, Results, and Discussion. Subheadings may be needed to clarify content. Other types of articles may need different formats.

When citing clinical laboratory data, please report in Systeme International (SI) units.

For more extensive information about preparing medical articles for publication, the editors suggest the following sources:

International Committee of Medical Journal Editors: Uniform requirements for manuscripts submitted to biomedical journals. The complete document is available in the June 1982 issue of the Annals of Internal Medicine.

Iverson C, Dan BB, Glitman P, et al: The American Medical Association Manual of Style, ed 8. Baltimore, Williams & Wilkins, 1989.

CBE Style Manual Committee: CBE style manual: a guide for authors, editors, and publishers in the biological sciences, ed 5, rev and expanded. Bethesda, Md, Council of Biology Editors, Inc, 1983.

In addition, many excellent books and manuals are devoted to principles and techniques of clear, concise writing, which are applicable to scientific as well as general topics.

REFERENCES

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Minimum acceptable data:

Journals: Authors, article title, journal, volume, inclusive pages, year.

Books: Author, title, place of publication, publisher, year.

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Legends should be in complete sentences, numbered, and typed on a separate sheet of paper.

Tables should be typed on separate sheets. Column headings should show points of similarity; side headings, points of difference.

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TexasMedicine

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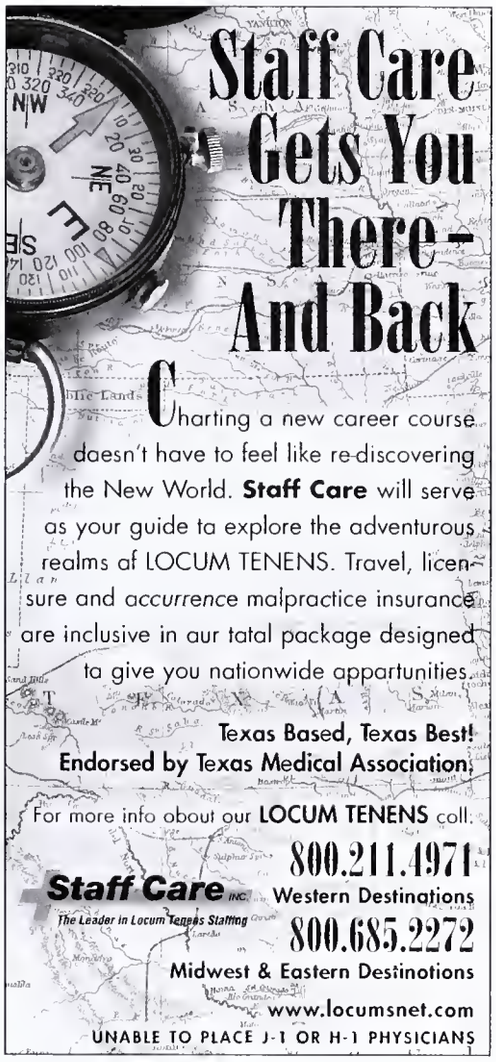

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Southwestern Center for Minimally Invasive Surgery: Laparoscopic Management of Common Bile Duct Stones, July 23-24. Sponsored by Department of Surgery and SCMIS. Located in the Simmons Biomedical Research Building, Excellence in Education Foundation Auditorium. CME credit offered. Course director: Robert V. Rege, MD. Contact Leah Cannon, (214) 648-3792.

New Approaches to Macular Degeneration, August 21. Sponsored by UT Southwestern Medical Center at Dallas Department of Ophthalmology, Excellence in Education Foundation Auditorium, Simmons Biomedical Research Building. Course director: A. Edwards, MD. CME credit offered. Contact: Stacey Novotny, (214) 648-3784.

Southwestern Center for Minimally Invasive Surgery: Stereotactic Breast Surgery, August 21-22. Sponsored by UT Southwestern Medical Center at Dallas, Excellence in Education Foundation Auditorium, Simmons Biomedical Research Building. Course director: A. M. Leitch, MD. CME credit offered. Contact: Leah Cannon, (214) 648-3792.

Fifth Annual Breast Care Advances and SCMIS Bioskills Training Conference, August 21-22, 1999. Sponsored by UT Southwestern Medical Center at Dallas, Department of Surgery. Simmons Biomedical Research Building, Excellence in Education Foundation Auditorium, Dallas. Course Directors: R. Rohrich, MD, G. Peters, MD, M. Leitch, MD, E. Frenkel, MD, and D. Jones, MD. CME credit offered. Contact Chelsea Yost, (214) 648-2200.

Women's Healthcare Nurse Practitioner Program: "22nd Annual Seminar in Women's Healthcare," July 19-22, 1999. Sponsored by UT Southwestern Medical Center at Dallas. Westin Galleria Dallas Hotel. CME credit offered. Course Director: Cynthia Allen. Contact Carron Hare, (214) 648-2136.

The Alliance for Medical Management Education Degree and Certification Program: Strategic Management of Healthcare Organizations (Module #6), August 1-7, 1999. Sponsored by UT Southwestern Medical Center at Dallas and the University of Dallas School of Management. American Airlines Training and Conference Center, Dallas. CME credit offered. Course Directors: J. Burnside, MD and J. McCracken, PhD. Contact Paul Krawietz, (214) 648-3705.

Uro-Gynecology Update, August 7, 1999. Sponsored by the UT Southwestern Medical Center at Dallas. The Melrose Hotel, Dallas. CME credit offered. Course Director: J. Schaffer, MD. Contact Jim O'Reilly, (214) 648-3794.

What's New is Gastroenterology & Hepatology, Sept. 18, 1999. Sponsored by UT Southwestern Medical Center at Dallas. Renaissance Dallas Hotel. CME credit offered. Course Directors: W. Peterson, MD and D. Thiele, MD. Contact Lisa Dunlevy (214) 648-9532.

Plastic Surgery for the Pediatrician, Sept. 25, 1999. Sponsored by UT Southwestern Medical Center at Dallas. Harold C. Simmons Biomedical Research Building, Excellence in Education Auditorium, Dallas. CME credit offered. Course Directors: H. S. Byrd, MD and P. C. Hobar, MD. Contact Jim O'Reilly, (214) 648-3794.

6th Annual Paul C. Peters Day in Urology, Oct. 1-2, 1999. Sponsored by UT Southwestern Medical Center at Dallas. Harold C. Simmons Biomedical Research Building, Excellence in Education Auditorium, Dallas. CME credit offered. Course Director: J. McConnell, MD. Contact Leah Cannon, (214) 648-3792.

LOOKING AHEAD–RADIOLOGY CME Diagnostic Radiology Update, Oct. 29-31, 1999. Course Directors: George Curry, MD and Helen Redman, MD. CME credit offered. Presented by UT Southwestern Medical Center at Dallas, the accredited sponsor, and Parkland Radiology Alumni Association. Contact Dolly Christensen, (214) 648-8013; fax (214) 648-2678; dchris@mednet.swmed.edu.

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TOMORROW'S MEDICINE TODAY

BackTalk

Question

What improvements would you suggest for future TMA annual meetings? What activities would you like to see again?

The following are anonymous responses to physician surveys given at TexMed '99, this year's annual meeting.

"More would come to TexMed if it were held in different facilities in which locations of talks were easy to find. More would come if it didn't take them away from their practices."

"If you are a [House] delegate, you cannot get CME readily. These need to be separated in time so that delegates meet when CME is not being offered and they do not miss as much."

"Change time — too many conflicts with children's school. Consider offering early and late programs for those who would like to do things with their families."

"What happened to the ER courses?"

"[The meeting needs] more focus on nursing home care."

"Continue with more diabetes teaching over the state to family practice and internal medicine."

"Continued talks about being a physician and its unique challenges."

"Hotel fees are very high considering doctors' shrinking collections in their offices."

"I believe all programs should be at one venue."

"Have the meeting on Saturday and Sunday, not Thursday and Friday. These are working days for doctors."

On the psychiatry continuing medical education (CME) track:

"We need sessions like this next year — ethics and medicine."

On the technology CME track:

"This needs to be repeated year after year, as we need to update our knowledge. We are fast beginning to learn this."

On the family practice CME track:

"Please, please, make it clinical! We are not researchers by choice. We are on the frontlines of medicine — little time with many patients to serve. Give us signs, symptoms, and treatment ideas. Save your pie charts, and instead fill our stomachs with clinical pearls and case studies. Your auditorium will be overflowing if you do this."

On the allergy, asthma, and clinical immunology CME track:

"Clinically oriented and useful in day-to-day practice."

On the alternative/complementary practices CME track:

"This course was quite good — I would recommend repeating it next year."

On the speakers:

"[The Sotiles] should be an annual invite and a prerequisite for medical marriages."

"I missed several of the lectures because I was in the [House of Delegates] meeting. It would be very helpful if we could have handouts from all of the speakers."

Back Talk is a nonscientific sampling of Texas physicians' opinions on a topic of interest. Physicians are polled by telephone, fax, or e-mail. We welcome suggestions for future topics. Send them to *Texas Medicine*, Back Talk, 401 W 15th St, Austin, TX 78701; fax them to (512) 370-1632; or e-mail them to larry_b@texmed.org.

Physician negotiations • Aetna merger • Payment advocacy

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August 1999

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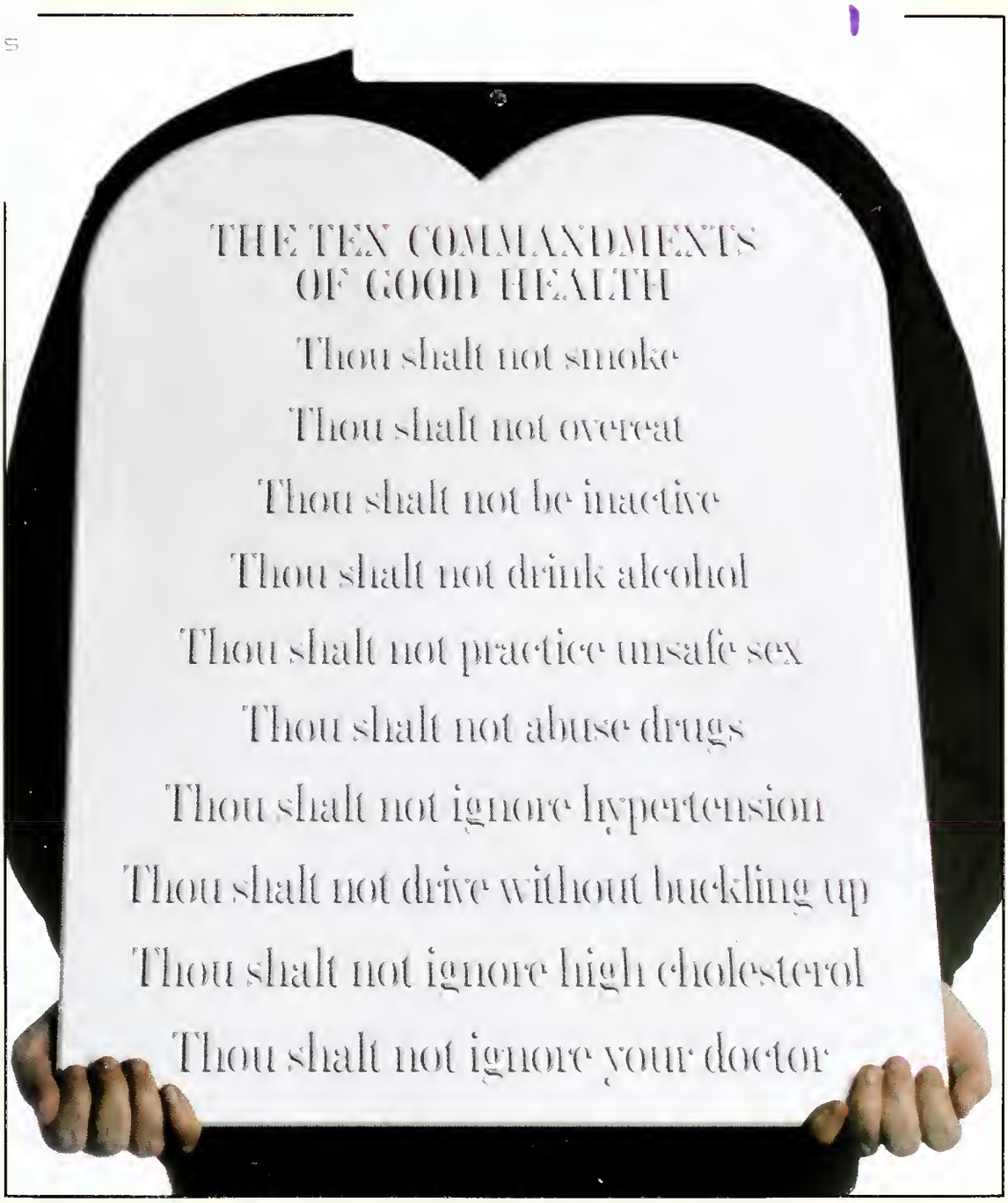

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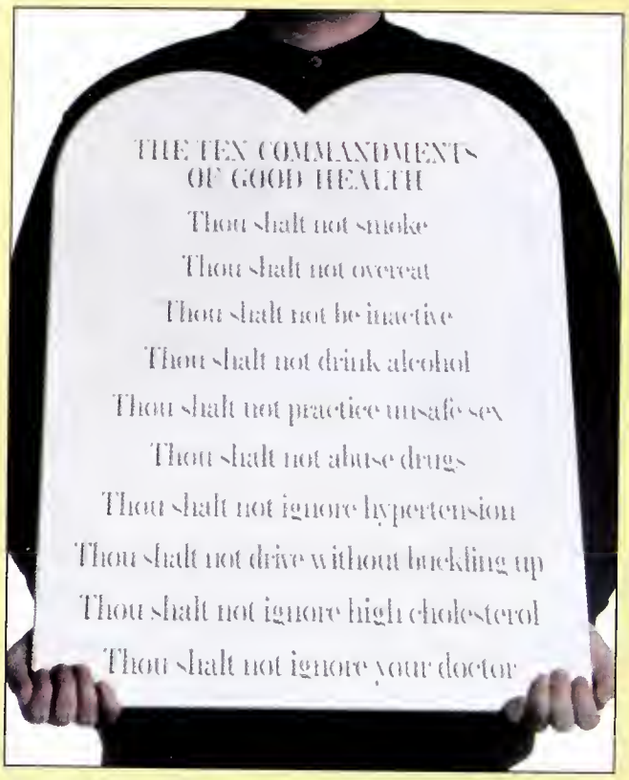

Cover illustration by Sean Ternamian

Counseling patients

Have you talked to your patients lately about changing unhealthy lifestyles, such as overeating, smoking, drinking too much, or not getting enough exercise? If not, you're probably not alone. Although the diseases that kill more people than any other are largely preventable, many physicians don't counsel their patients on changing their ways.

By Johanna Franke

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The Journal

Chart documentation of clinical preventive services at 9 Texas clinics — 56

By Michele Murphy Smith, MA, RN, RD; Nell H. Gottlieb, PhD; Barbara Meyer, MS; Philip Huang, MD, MPH; Patricia Goodson, PhD

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August 1999

Legislative Affairs

Antitrust defense 28

The Texas Medical Association has scored another major legislative victory in its efforts toward fairness for physicians and their patients with passage of the Physician Negotiation Bill in the recent session of the legislature. Passed with help from the American Medical Association and the TMA Alliance, the bill makes Texas the first state to give physicians a defense when insurers threaten antitrust action.

By Ken Ortolon

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Medical Economics

The Aetna battle 42

Organized medicine could have stood by and done nothing when Aetna US Healthcare announced plans to merge with Prudential and dominate the health care market. It didn't, and as a result, federal and state regulators have ordered Aetna to sell some of its Texas holdings.

By Teri Moran

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Medical Economics

Payment advocacy 46

Fed up with being hassled by insurance companies over reimbursement for treating patients? Judging by the increase in Hassle Factor Log complaints TMA has received, many of you are. TMA has a payment advocacy team that gets results. Their efforts, along with a tougher new prompt payment law, may make your life a little easier.

By Teri Moran

Law Page 52

Law

Suing Blue Cross and Blue Shield 52

Disputes with physicians over the procedures it uses for reimbursing doctors for their services have landed Blue Cross and Blue Shield in court in two separate lawsuits.

By Monica Maldonado

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The Big Picture

Sunset on Ocracoke Island, NC, by Edward Racht, MD, Austin

If you would like to submit a photograph for The Big Picture, please send it to Laura J. Albrecht, Photo Editor, *Texas Medicine*, 401 W 15th St, Austin, TX 78701.

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Editor's Note

I need to lose weight . . . a lot of it. But my primary care physician has never raised the subject. The only time we talk about weight loss is when I initiate the conversation. A coworker says his doctor doesn't talk to him about quitting smoking. The same goes for one of our magazine designers.

While admittedly only anecdotal, these cases back up an unfortunate discovery Associate Editor Johanna Franke made while researching this month's cover story, "Choosing Change," pp 34–41. Even though many public and private health groups recognize the importance of physicians' encouraging patients to stop the risky behavior that leads to heart disease, cancer, and stroke, most physicians don't.

It's not that physicians don't care. It seems that lack of time, resources, and counseling skills keep them from having meaningful heart-to-heart talks with their patients.

Johanna's story delves into the issue of convincing patients to mend their ways and offers some valuable tips on how to discuss unpleasant subjects.

Also in this issue, Senior Editor Teri Moran and Associate Editor Ken Ortolon tell how TMA and AMA won two major victories for physicians and patients. Teri reports on organized medicine's successful efforts to persuade federal and state regulators to order Aetna to sell its holdings in Houston and Dallas before buying Prudential. And, Ken goes behind the scenes to detail how the Physician Negotiation Bill was passed by the Texas Legislature despite strong opposition from the insurance industry.

Larry BeSaw
Managing Editor

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From Your President

An open letter to Texas Medical Association and county medical society members and staff

By Alan C. Baum, MD, TMA president

My dad taught me early in life that a good start is the key to success in any endeavor. If the first 6 weeks of my term as TMA president are any indication, the next year will be a banner year for this association, the physicians of Texas, and our patients.

And you deserve all the credit.

Our biggest success to date — the partial derailing of Aetna US Healthcare's plans to merge with Prudential Healthcare — has truly been a team effort . . . a team success. Physicians and staff from the TMA, the county societies, and the American Medical Association collaborated in almost unprecedented fashion. The federation of medicine made the Department of Justice listen to — and act upon — our very grave and significant concerns over the anticompetitive imbalance this merger would create for our patients and for our practices.

Patients in Houston and Dallas, and the physicians who care for them, are the winners in the proposal for Aetna to sell off its NYLCare health plans in those two cities before it is allowed to gobble up Prudential in Texas and nationwide. We have broken new ground in that the litmus test for future health industry mergers will be not only the size of the plans involved but also their conduct and patient-friendly performance.

All of this came just 2 weeks after the close of the Texas legislative session, which was a tremendous success for Texas medicine. The landmark Physician Negotiation Bill passed the House and Senate in landslide fashion, and Gov George W. Bush signed the bill into law. It will finally give independent physicians some leverage in negotiating fair and patient-friendly contracts with the investor-driven managed care plans. Once again, Texas leads the nation in establishing health care policy that honors the patient-physician relationship.

Other significant legislative advances on behalf of physicians and patients include:

- Expanding the Children's Health Insurance Program to cover all children aged 18 and younger whose families earn less than 200% of poverty.
- Requiring health plans to pay clean claims within 45 days and imposing a $1,000-a-day fine for late payments.

Our biggest success to date — the partial derailing of Aetna US Healthcare's plans to merge with Prudential Healthcare — has truly been a team effort . . . a team success.

- Ensuring that physicians in group practices continue to have access to their patients even if they leave the group.
- Protecting the confidentiality of physicians' Social Security numbers on file with state agencies and restricting the use of physicians' federal DEA numbers to their appropriate purpose.
- Limiting optometrists' independent treatment options and prohibiting them from performing surgery.
- Designating the $1.8 billion first installment of the state's tobacco lawsuit settlement for major public health, antismoking, research, and other health care initiatives.
- Setting new net worth and solvency requirements for health maintenance organizations.

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From Your President

For fear of leaving someone out, I'm hesitant to thank by name those physicians and staff members whose hard work made all of this possible. But I'll take that risk because the following people really do need to be recognized and publicly appreciated:

- The Council on Socioeconomics under the leadership of Dr Bohn Allen, of Arlington, and Dr Paul Handel, of Houston;
- Dr Bob Sloane, of Fort Worth, and the members of the Council on Legislation;
- Dr Robert Gunby, Dr Gordon Green, and Michael Darrouzet and the staff of the Dallas County Medical Society;
- Dr Carlos Hamilton and Greg Bernica and the staff of the Harris County Medical Society;
- Dr Randy Smoak, Dr Donald Palmisano, and Dr Andy Anderson and the AMA staff;
- The dedicated staff in TMA's Office of General Counsel and divisions of Public Affairs, Medical Economics, and Communication; and
- All the physicians and alliance members who called, wrote, and visited their state representatives and senators and answered our surveys about how the Aetna-Prudential merger would affect your practice.

I want to personally thank each of you — and all the others — for working so hard and cooperating so well to make all of this happen. These are tremendous examples of the power in the voice of 36,000 TMA members speaking in unison.

Alan C. Baum MD.

Alan C. Baum, MD
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- Luncheon courtesy of Texas Medical Liability Trust
- Afternoon risk management seminar, "Was It Something I Said? The Underlying Psychology of Medical Malpractice" (Seminar fee required)
- AMA Internet Technology Health Day Program, Friday, Sept. 17, 8 a.m. to 4:30 p.m.
- Networking Reception, Friday, 4:30 to 7 p.m.
- TMA committee, council, board and section meetings, Sept. 17 and 18

Exciting Extras

- Valuable AMA PRA Category 1 CME credit
- Free registration for TMA members, including the AMA Internet Technology Health Day
- On-site child care available
- Austin area attractions, including UT vs. Rice football — call (800) 982-BEVO for tickets

**For more information , call (800) 880-1300, ext. 1346,
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or visit TMA's Web site at www.texmed.org.**

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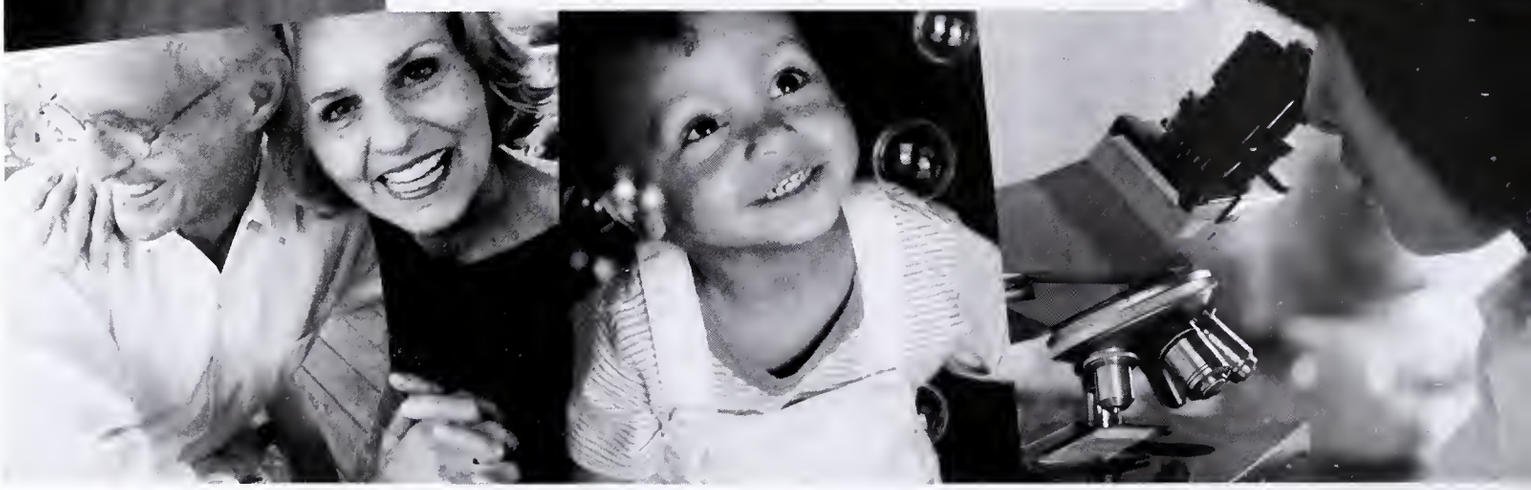

People

Newsmakers

Fritz E. Barton, Jr, MD, Dallas, was elected president of the American Society for Aesthetic Plastic Surgery.

Jack W. Bonner III, MD, Greenville, SC, was elected second vice president of the American College of Psychiatrists and president-elect of the Group for the Advancement of Psychiatry.

F. Charles Brunicardi, MD, was appointed chair of the Michael E. DeBakey Department of Surgery at Baylor College of Medicine in Houston.

Dale D. Burleson, MD, El Paso, was elected secretary-treasurer of the Texas Society of Colon and Rectal Surgeons.

Houston urologist **C. Eugene "Gene" Carlton, MD,** received the Harry M. Spence, MD Memorial Lifetime Service Award from the Texas Urological Society.

Anesthesiologist **Judith L. Craven, MD,** and cardiologist **Kenneth L. Mattox, MD,** both of Houston, received Distinguished Alumni awards from the Baylor Medical Alumni Association.

Bay City internist **Ali Tarkan Dural, MD;** Austin pediatrician **David Grundy, MD;** Nacogdoches family practitioner **Aaron Polk, MD;** Texas City family practitioner **John Reeves, MD;** and Longview internist **James W. Sawyer, MD,** received 1999 Teacher of Distinction awards from The University of Texas Medical Branch's School of Medicine, the Office of Primary Care Education, and the East Texas Area Health Education Center.

Fritz E. Barton, Jr, MD

Dale D. Burleson, MD

John Hunt, MD

Gary Purdue, MD

Robert Munford, MD

Stanley S. Wang, JD

Houston pediatric infectious disease specialist **Ralph D. Feigin, MD,** and his wife, Judith Feigin, EdD, were honored for their contributions to pediatric medicine, the medical profession, their community, and the State of Israel at the State of Israel Maimonides Award Dinner.

Infectious disease specialist **Stephen B. Greenberg, MD,** and pediatric nephrologist **L. Leighton Hill, MD,** both of Houston, were recognized as Distinguished Faculty by the Baylor Medical Alumni Association.

Temple plastic surgeon **Peter C. Grothaus, MD,** received a humanitarian award from the National Secretary of the Family, a government agency in El Salvador, for 10 years of service to the children of El Salvador through the Austin Smiles program.

The 1999–2000 Texas Dermatological Society officers include **William R. Holder, MD,** Baytown, president; **David Madorsky, MD, MPH,** San Antonio, president-elect; **Toni Funicella, MD,** Austin, vice president; and **D. Scott Miller, MD,** Fort Worth, secretary-treasurer.

John Hunt, MD, and **Gary Purdue, MD,** both general surgeons from Dallas, re-

Please let *Texas Medicine* know about your honors and achievements. Criteria for inclusion in the Newsmakers section are TMA membership; election or appointment to an office of, or honors from, a national or state organization; or, space permitting, recognition at the local level. Items for the Newsmakers section are published at the discretion of the managing editor. Submit items for consideration, with photos if possible, to People, *Texas Medicine*, 401 W 15th St, Austin, TX 78701; fax (512) 370-1632; e-mail larry_b@texmed.org.

ceived 1998 Parkland Memorial Hospital Distinguished Physician awards.

Azle family practitioner **Frank Lonergan, MD,** was selected as a 1999 Physician of the Year by the VistaCare Foundation, a national nonprofit organization that provides support and advocacy for patients and families facing life-limiting illnesses.

Internist **Edward C. Lynch, MD**, and pediatric radiologist **Edward B. Singleton, MD,** both of Houston, were among the first winners of The Corbin and Barbara Robertson Presidential Award for Excellence in Teaching, which recognizes Baylor College of Medicine faculty members who have made long-standing, consistent, and highly valued contributions to Baylor's educational mission.

Dallas internist **Robert Munford, MD,** was elected to the Association of American Physicians, a 114-year-old nonprofit professional organization founded to advance scientific and practical medicine.

Austin cardiothoracic surgeon **John D. Oswalt, MD,** was named 1999 Cardiac Care Provider of the Year by the American Heart Association.

Austin pathologist **Maureen A. Riopel, MD,** received the 1998 International Society of Gynecological Pathologists award for a meritorious publication in the *International Journal of Gynecological Pathology.*

Tibor Ruff, MD, Temple, was elected president of the Texas Association of Otolaryngology.

The 1999–2000 Texas Urological Society officers include **Gary W. Smith, MD**, Houston, president; **Jonathan Vordermark, MD,** Fort Worth, president-elect; and **Michael Dragun, MD,** Midland, secretary-treasurer.

Stanley S. Wang, JD, a third-year medical student at The University of Texas Southwestern Medical School at Dallas, won the 1999 Student Writing Competition of the State Bar of Texas' Health Law Section for his paper on the Food and Drug Administration's regulation of off-label drug uses.

Deaths

Robert Cary Atmar, MD, 96; San Antonio; Baylor College of Medicine-Dallas, 1929; died May 23, 1999.

Jack William Avery, MD, 77; Fort Worth; The University of Texas Southwestern Medical School at Dallas, 1951; died May 24, 1999.

Joe Weldon Bailey, MD, 84; Austin; Baylor College of Medicine-Dallas, 1939; died May 20, 1999.

Byron Duke Braly, MD, 69; Irving; Baylor College of Medicine, 1954; died May 7, 1999.

Melbourne J. Cooper, MD, 97; Boerne; The University of Texas Medical Branch at Galveston, 1927; died April 26, 1999.

James Robert Crisp III, MD, 64; Lubbock; University of Tennessee College of Medicine-Memphis, 1966; died May 31, 1999.

Robert Burl Elliott, MD, 79; Houston; University of Iowa College of Medicine, 1943; died May 27, 1999.

Tracy Davis Gage, MD, 74; Lubbock; The University of Texas Medical Branch at Galveston, 1955; died May 20, 1999.

William Thomas Gordon, Jr, MD, 67; San Angelo; University of Oklahoma College of Medicine, 1958; died May 6, 1999.

Roy Henry Desmond Harris, MD, 73; Houston; University of Alberta Faculty of Medicine, 1957; died May 1, 1999.

Joseph MacGalashan Hill, MD, 94; Dallas; State University of New York at Buffalo, 1928; died May 21, 1999.

Alexander Giboney Juden, Jr, MD, 68; San Antonio; The University of Texas Medical Branch at Galveston, 1956; died June 4, 1999.

Leonard Meltzer, MD, 83; Houston; Louisiana State University School of Medicine-New Orleans, 1941; died June 6, 1999.

Richard John Puls, MD, 73; Dallas; Washington University School of Medicine-St Louis, 1950; died June 1, 1999.

Beverly Lee Reynolds, MD, 76; Dallas; University of Virginia School of Medicine, 1952; died May 21, 1999.

Mario Jesus Sanchez, MD, 75; Houston; Havana College of Medicine, 1951; died May 27, 1999.

E.B. Sanford, MD, 91; Palacios; The University of Texas Medical Branch at Galveston, 1942; died May 28, 1999.

William Kemp Strother III, MD, 61; Dallas; Duke University School of Medicine, 1962; died May 25, 1999.

Providing A Critical Resource For The Referring Physician: Cook Children's Talks With Dr. David F. Turbeville.

DR. DAVID F. TURBEVILLE — MEDICAL DIRECTOR OF NEONATOLOGY

DR. TURBEVILLE, MANY HOSPITALS HAVE NEONATOLOGY UNITS. WHY DO REFERRING PHYSICIANS PREFER THE COOK CHILDREN'S NEONATOLOGY UNIT OVER OTHERS?

We respond rapidly and thoroughly to the requests of referring physicians. When they need help, we try to get it to them as soon as possible. We often have our transport team en route within 15 minutes of their requests. In addition, Cook has a "Level 4" NICU with multiple specialists available to us. This expertise gives our patients exposure to the most sophisticated care available.

COOK CHILDREN'S IS KNOWN FOR HAVING ONE OF THE BEST NEONATAL TRANSPORT TEAMS IN THE COUNTRY. WHAT SETS THEM APART FROM OTHER TRANSPORT TEAMS?

The team is made up of highly trained physicians, nurses and respiratory therapists who are experts in newborn stabilization and care. Our team pioneered the use of jet ventilators for transport use. We can transport by ground ambulance, helicopter, and airplane as needed. We have the only jet plane in the country dedicated to transport of pediatric patients. This allows us to get to the patient as rapidly as possible. Because of our speed, we are frequently able to get to a referring hospital in time to attend many high-risk deliveries.

DR. TURBEVILLE, IN YOUR OPINION, WHAT IS IT THAT REFERRING PHYSICIANS WANT MOST FROM THEIR RELATIONSHIP WITH A SPECIALIST?

Confidence that his needs and his patients' needs will be met. The referring physician can depend on us to respond rapidly and with quality care. The referring physician also wants adequate follow-up. Therefore, we make frequent calls back to the referring hospitals, and when the baby is discharged, we send a fax to the referring physician which details the baby's hospital stay.

CAN YOU RELATE AN INTERESTING CASE THAT EXEMPLIFIES THE TRUST A REFERRING PHYSICIAN PUTS IN WHAT YOU DO HERE?

Last year we had a mother from a referring hospital who was in the throes of early labor. We were called and made it to the hospital in time for the delivery of a very small baby (500 grams). The baby was incubated and given Survanta by our team and then transported back to Cook. The hospital stay here was about two months and was characterized by respiratory distress, infections, and PDA surgery. The baby was transferred back to his community hospital weighing 1600 grams and was then discharged in healthy condition and weighing 1900 grams.

Cook Children's Medical Center is located in Fort Worth, Texas. For more information about Dr. Turbeville and our other Neonatologists — Cody Arnold, Samual Juliao, Richard A. Sidebottom, Kim G. Smith, Michael D. Stanley and Michael J. Stevener — call 1-800-COOK517.

CookChildren's
Medical Center

Texas Medicine Rounds

By Johanna Franke

AMA votes for negotiating unit in stormy session

By Steve Levine, TMA communication director

In a move that engendered both excitement and disappointment from physicians and the public, the American Medical Association House of Delegates voted to create national labor organizations for employed physicians and for house staffs as part of its strategy to help doctors regain control of their profession. This historic vote took place at AMA's 148th annual meeting June 20–24 in Chicago.

The Texas delegation to the AMA opposed the move, which does little to immediately improve the negotiating power of self-employed physicians, who comprise an estimated 64% of postresidency physicians. The Texans unsuccessfully urged the House to rely primarily upon the "state action doctrine" of antitrust law to bolster physicians' joint standing at the negotiating table, as the Texas Legislature recently approved. (See "Antitrust Defense," pp 28–32.)

Both sides in the passionate debate argued that a labor-oriented move would have significant impact on AMA's dwindling membership roles. Both sides argued for the primacy of physicians' professional standing in the community. All agreed that the stakes have grown too large for organized medicine to ignore.

"American physicians are angry, frustrated, and exhausted over the intrusions of managed care organizations into the day-to-day practice of medicine," said Austin internist William G. Gamel, MD, chair of the Texas delegation, at the opening of the debate. "And they are looking to us — their representatives at the local, state, specialty, and national levels — to help them find a way to practice their profession as they've been trained. They're looking to us to help them find a way to take back medicine for themselves and for their patients."

> "None of us really want a union or anything that sounds like a union. That strategy will hurt membership."

The Texas way

The Texas delegation stood strong in support of the AMA Board of Trustees' initial recommendation that the AMA "not form or sponsor any 'labor organization' [as defined by the National Labor Relations Act]."

"None of us really want a union or anything that sounds like a union," said Fort Worth urologist Hugh Lamensdorf, MD. "That strategy will hurt membership."

The Texans instead proposed a two-pronged approach based on the patient-physician advocacy projects that have worked well for the Texas Medical Association: the Physician Negotiation Bill (Senate Bill 1468), which the Texas Legislature passed by an overwhelming majority earlier this year, and TMA's one-on-one "in-the-trenches" advocacy efforts with individual physicians, their office staffs, and third-party payers. (See "Getting Blood from Turnips," pp 46–50.)

SB 1468 allows independent physicians to jointly negotiate with health plans under the "state action doctrine" protection from federal antitrust prosecution. Throughout the debate on it, "We were very careful to avoid using the terms 'collective bargaining,' 'labor organization,' 'union,' 'work stoppage,' or 'strike.' By avoiding that, we were

able to keep to the high ground," said Arlington surgeon Bohn D. Allen, MD.

Waco internist Joe H. Cunningham, MD, pointed out that Texas Gov George W. Bush signed SB 1468 into law on the day that AMA's 148th annual meeting convened. "Governor Bush signed that bill not because it was a union bill, but because it was *not* a union bill," Dr Cunningham said.

The bill grew out of a collaboration between TMA and the AMA's Division of Private Sector Advocacy. Although both the AMA Board of Trustees' proposal and the House of Delegates' final document recommended strengthening such collaboration, the Texas delegation proposed that the AMA place the private sector advocacy programs at the forefront.

Dr Allen pointed out that TMA's advocacy efforts had helped to slow or derail some insurance companies' attempts to bundle or downcode physicians' claims, to impose gag clauses and the mandatory use of hospitalists, and to shift liability for their negligent acts to their contracting physicians. "This would be one of the most high-profile AMA benefits that members would recognize," Dr Allen said.

A question of membership and professionalism

The House action that spawned the most acrimonious debate and earned extensive, nationwide media coverage was the vote for the AMA to "immediately implement a national labor organization under the National Labor Relations Act [NLRA] to support the development and operation of local negotiating units as an option for employed physicians." The AMA estimates that approximately 126,000 doctors, or 26% of US physicians who have completed residencies, would be eligible for such a service.

Much of the support for this proposal came from young physicians, residents, and medical students, and from states where a large proportion of the physicians are employed. They argued that taking this action could help reverse the AMA's precipitous decline in membership.

"The AMA must be in the leadership of doing this," said Gary F. Krieger, MD, a delegate from California. "I know it's a gamble, but 400,000 physicians in America no longer have faith in us. Are we relevant to the practicing physicians of America? No."

Fort Worth pediatrician Melissa J. Garretson, MD, delegate from the Young Physicians Section (YPS), says a national labor organization would give employed physicians another tool to help their patients stand up to the abuses of investor-driven managed care plans. "I want this not necessarily for money, not for reimbursement, but so I can stand up and fight for my patients," she said.

Opponents argued the vote would hurt membership by dividing the AMA on philosophical grounds and that media coverage of the debate would damage both the AMA's image among physicians across the country and physicians' image among their patients.

"Words do matter," said Fort Worth allergist Susan Rudd Wynn, MD, whose comments to the House were carried by the national media. "We are not mere laborers, we are not strikers, we are not simply providers. We are servants. . . . We are professionals, and if we abandon our professionalism in the heat of the moment, we are lost."

Lost in the headlines was a piece of the final document that promised adherence to the Principles of Medical Ethics and the Current Opinions of the AMA Council on Ethical and Judicial Affairs (CEJA). Dallas ophthalmologist Robert M. Tenery, Jr, MD, immediate past chair of CEJA, noted that CEJA guidelines prohibit physicians from using strikes, work stoppages, or other tactics that would interfere with patient care.

"We have our own standards and should engage in professional advocacy to serve patients and the public health without the encumbrance of being like, thinking like, or appearing like a trade and labor group — and without being a house internally divided," Dr Tenery said.

Dr Garretson says that is exactly why the AMA needed to take immediate action. "Better organized medicine than organized labor," she said.

Antitrust relief

The AMA's strongest weapon for self-employed physicians needs help from Congress. In the midst of the House of Delegates' debate, AMA Executive Vice President E. Ratcliffe "Andy" Anderson, Jr, MD, traveled to Washington, DC, to testify on behalf of HR 1304, the Quality Health Care Coalition Act of 1999, introduced by Reps Tom Campbell (R-Calif) and John Conyers (D-Mich).

The so-called Campbell Bill would change federal antitrust laws to allow independent physicians to negotiate collectively with health maintenance organizations and other health insurers just as labor organizations can bargain under the NLRA. The bill also prohibits strikes and other actions that would interfere with patient care.

"The antitrust laws must be reformed to restore physicians' ability to act effectively as patient advocates," Dr Anderson told a congressional committee. "The Campbell Bill would create a more level playing field so that physicians can carry out their obligation to stand up for what their patients need."

The final document approved by the House of Delegates calls on AMA to "be prepared to immediately implement a national organization to support development and operation of local negotiating units as an option for self-employed physicians and medical groups" when the bill becomes law. AMA legislative strategists cautioned that the bill faces an uphill fight in Congress without the support of key leaders in the House and Senate.

"We are not mere laborers, we are not strikers, we are not simply providers. We are servants. . . . We are professionals, and if we abandon our professionalism in the heat of the moment, we are lost."

Support for residents

Currently, about 10,000 of the nation's 95,808 resident physicians belong to unions. The National Labor Relations Board (NLRB), however, classifies residents as students — not employees — and thus not eligible for protection under the NLRA. AMA policy considers residents to be both employees and students who are entitled to collectively negotiate over working conditions but not over issues related to their education.

The House of Delegates took the following three-part approach to the concerns of resident and fellow physicians:

- To immediately implement a national labor organization to support the development and operation of local negotiating units as an option for resident and fellow physicians who are authorized under state laws to bargain collectively;
- To continue to support the development of independent house staff organizations and to be prepared to implement a national labor organization should the NLRB rule that resident physicians are employees; and
- To continue to work with the Accreditation Council for Graduate Medical Education to find ways to address residents' concerns and grievances and to develop a model for local house staff organizations that could mediate disputes between residents and their sponsoring institutions.

Not surprisingly, representatives of resident physicians and medical institutions adopted opposing viewpoints on this question.

"Oh, how I wish the AMA had something to offer residents and fellows," said Liana Puscas, MD, of California, the newly elected resident physician on the AMA Board of Trustees.

Aftermath

Delegates and alternates left the Chicago meeting concerned over how to explain some unsettling headlines to their colleagues and wondering how the vote would be interpreted and implemented. AMA and TMA leaders offered some perspective.

"We regret that the AMA House of Delegates chose to endorse creation of a national labor organization," said TMA President Alan C. Baum, MD, of Houston. "However, we understand that the AMA House of Delegates represents physicians in every specialty and in every community across the nation. Some of our colleagues in other parts of the country may find that the Texas approach is inappropriate; those physicians needed the AMA House of Delegates to act as it did today."

TMA is exploring all options to represent physicians in their negotiations with managed care organizations and other insurers, including the possible creation of a TMA "representation unit" for member physicians under the new state law, says Louis J. Goodman, PhD, TMA executive vice president.

Randolph Smoak, Jr, MD, chair of the AMA Board of Trustees, announced that the board would meet immediately to plan its next steps.

"We will waste no time in turning the delegates' mandate into reality," Dr Smoak said. "And we'll report a full action plan within the next 30 days on how we will add this powerful new option to an already impressive array of tools that AMA physicians are using all across the country to fight for their patients' best interests." ★

> "I want this not necessarily for money, not for reimbursement, but so I can stand up and fight for my patients."

AMA House of Delegates tackles Medicare billing, mammograms, and ethics; Texas candidates sweep to victory

Before and after the contentious debate on collective negotiating for physicians, delegates at the 148th Annual Meeting of the American Medical Association House of Delegates debated and adopted policy positions on Medicare billing and documentation guidelines, mammography for women aged 40 to 50, and ethical guidelines for the sale of nonprescription, health-related products from physicians' offices.

More than 60 Texas physicians representing the Texas Medical Association and various sections and national specialty societies participated in the June 20–24 meeting in Chicago. The House adopted all or part of five of the six resolutions carried by the Texas doctors and elected three TMA members to AMA offices.

Medicare billing and documentation

Numerous physicians from all parts of the country spoke out against what they called the "irresponsibility" of the Health Care Financing Administration (HCFA) and the American Association of Retired Persons (AARP) for their misguided efforts to curb Medicare fraud and abuse. Particularly galling was HCFA's policy of paying a "bounty" to patients for reporting their physicians suspected of health care fraud.

The House voted to seek an independent audit of Medicare Part B expenses to determine the extent of what HCFA calls "fraud," to "express anger and outrage" toward HCFA and the AARP for undermining the patient-physician relationship, and to "use all available means" to have HCFA immediately rescind the "bounty" policy.

Delegates also revisited AMA's 1998

plan for revising the Medicare evaluation and management (E&M) documentation guidelines. The House directed the AMA Board of Trustees to assume responsibility for implementing the changes mandated by the 11-point plan and to work with HCFA to "implement, test, and appropriately evaluate E&M pilot projects prior to adopting a new E&M documentation system." The E&M plan includes strong opposition to "numeric counting systems" in the medical record and a request for HCFA to replace random audits with a focused review program that includes peer review of statistical outliers.

New mammogram guidelines

On another divisive issue, the House voted to recommend that all women aged 40 to 50 receive yearly mammograms; previous AMA policy had advocated a 1–2 year timetable for women in their 40s. The health care community is split on the question. The AMA now sides with the American Cancer Society and the American College of Surgeons. The American College of Obstetricians and Gynecologists and the National Cancer Institute support the 1–2 year timetable.

The delegates backed a report from the AMA Council on Scientific Affairs that stated, "Current epidemiological evidence now demonstrates the efficacy of mammography screening for detecting cancer in women in their 40s. Cost effectiveness of screening mammography has been found to be within the range of other diagnostic procedures when expressed as marginal cost per year of life saved."

Sale of health-related products

The House once again debated an opinion from the AMA Council on Ethical and Judicial Affairs (CEJA) that lays out guidelines for the sale of health-related products from a physician's office. The House adopted the CEJA report that recommends physicians not sell health-related products whose claims of medical benefits lack scientific validity. The guidelines are "designed to limit conflicts of interest, minimize the risk of brand endorsement, and ensure a focus on benefits to patients."

Steve Levine

John P. Howe III, MD, San Antonio, and Joseph P. Annis, MD, Austin, celebrate their election to AMA council posts.

Opponents argued that the guidelines are confusing and may further alienate AMA members who feel the sale of these products helps them keep their practices afloat. Supporters responded that the guidelines would prevent patients from feeling exploited by their physicians. "Our professionalism is being sold one bottle at a time," one delegate said.

More than 60 Texas physicians representing the Texas Medical Association and various sections and national specialty societies participated in the June 20–24 meeting in Chicago.

Texans gain AMA posts

All three Texas candidates for elected positions at the AMA won their elections. John P. Howe III, MD, of San Antonio, won reelection to the Council on Scientific Affairs; Austin anesthesiologist Joseph P. Annis, MD, won a slot on the Council on Medical Service; and Zoltan Trizna, MD, a resident at The University of Texas Medical Branch at Galveston, claimed the resident physician position on the Council on Scientific Affairs.

Also at the Chicago meeting, Houston psychiatrist Priscilla Ray, MD, was appointed to a seat on CEJA. Tracy R. Gordy, MD, a psychiatrist from Austin, was named chair of the AMA's Current Procedural Terminology Editorial Panel.

WHAT YOUR PATIENTS ARE READING

Dateline: Health

By Laura Albrecht

The following is a collection of current consumer magazine articles that feature health and medical information. Send your suggestions and comments to Laura Albrecht, *Texas Medicine*, 401 W 15th St, Austin, TX 78701; or e-mail laura_a@texmed.org.

"TEXAS HEROIN MASSACRE." Visit the world of heroin and its young victims in Plano. *Rolling Stone*, 5/27/99

"DO YOU HAVE HEPATITIS C?" Women are alerted about the risk of contracting hepatitis C through blood transfusions during cesarean sections. *Shape*, 6/99

"BEWARE THE UNRULY SUN." Medical sources chant the not-so-mystical mantra of prevention and detection. *Newsweek*, 6/21/99

"IT CAN HAPPEN TO ANYONE." The highs and lows of a high-profile basketball player and her life-threatening opponent — bulimia — are revealed. *Sports Illustrated for Women*, Summer 1999

"HOW SHY IS TOO SHY?" Ranking behind depression and alcoholism, this mental disorder — shyness — takes over the lives of one out of every eight people in the United States. *US News*, 6/21/99

"ALWAYS BE . . . WITH TEA." A trauma surgeon offers tips on what to pack in first-aid kits before treks into the great beyond. *Outside*, 6/99

"BOTHERSOME BUNIONS OUCH!" This pesky foot problem can bring on miles of pain, and the end result may be a conversation with an orthopedic surgeon. *Runner's World*, 5/99

"7 TESTS YOU NEED." The importance of medical tests to prevent heart disease, breast cancer, colorectal cancer, skin cancer, osteoporosis, cervical cancer, and hypertension is reviewed. *Health*, 6/99

"I SURVIVED A DEADLY VIRUS." A New Mexico woman overcomes the deadly hantavirus. *Ladies Home Journal*, 7/99

"THE FORGOTTEN CHILDREN." Children cope with life after their mothers have died from AIDS. *Redbook*, 7/99

Three Texas physicians served as members of House reference committees at the meeting. Dallas psychiatrist Byron L. Howard, MD, was a member of the reference committee on amendments to the AMA constitution and bylaws; Robert P. Carroll, Jr, MD, a family practitioner from Nacogdoches, served on the reference committee on medical service issues; and Houston neurologist Harris M. Hauser, MD, was a member of the public health reference committee.

Other issues merit action

Bryan family physician Nancy W. Dickey, MD, concluded her term as the AMA's first woman president. She continued her call for the AMA to champion universal access to health care. "Forty-three million of our fellow citizens lack access to care — and a way to pay for it," Dr Dickey told the House. "We will be making access a vital part of this nation's presidential platform for the candidates running in the year 2000."

Thomas R. Reardon, MD, a general practitioner from Boring, Ore, was sworn in as the new AMA president, saying the profession faces "a time of opportunity." Dr Reardon will address the TMA 1999 Fall Conference on September 18 in Austin. The delegates unanimously voted to name Randolph D. Smoak, Jr, MD, a general surgeon from Orangeburg, SC, and chair of the AMA Board of Trustees, as president-elect.

Delegates addressed various other economic, legislative, public health, and organizational topics. The House:

- Asked the AMA to oppose pharmacists being given the authority to initiate or modify drug treatment except on a case-by-case basis at the specific direction of a physician;
- Encouraged the AMA to support legislation to prohibit unannounced visits to physician offices by government investigators and agents;
- Advocated that Medicare coverage of prescription medication be addressed only in the broader context of transforming Medicare into a fiscally solvent program;
- Called on the AMA to advocate that utilization efforts focus on statistical

outliers, rather than blanket review of whole populations of physicians or all instances of particular services, and that managed care plans restrict preauthorization requests to physicians whose claims have shown to be statistical outliers;

- Recommended assessing the value of existing clinical skills assessment examinations for medical students, with support for a national examination to test clinical skills;
- Encouraged physicians to participate in the development and use of immunization registries for their communities; and
- Called on state medical licensing boards to require a full, unrestricted license to practice telemedicine in their states.

Action on Texas resolutions

The Texas delegation carried six resolutions to Chicago. Three of the resolutions — on Medicare reform, on the reform of federal tax laws to encourage individual ownership of health insurance, and on federal protection of the privacy of medical records — were incorporated into related House action adopted on those issues.

In a two-part resolution, the House did not go along with Texas' request that the AMA help restore full Medicare funding for training in child neurology, but the delegates adopted policy directing the AMA to support full funding for residency training until the time the resident is eligible to become board certified. The sixth Texas resolution proposed creating an AMA Council on Membership. The House chose instead to direct its special Task Force on Membership, chaired by Nacogdoches ophthalmologist Lyle S. Thorstenson, MD, to continue its work in finding ways to bolster AMA membership.

The Texas resolution asking the AMA to continue to support state and national efforts to reform antitrust laws to improve physicians' ability to negotiate patient-friendly contracts with managed care plans became part of the AMA's new National Negotiating Organization policy. ★

SUMMARIES OF RECENT HEALTH CARE FINDINGS

In Case You Missed It

The risk of invasive breast cancer can be reduced by 75% when raloxifene is used to treat osteoporosis in postmenopausal women. *Journal of the American Medical Association*, 6/16/99

Childhood cancer mortality rates declined 58% between 1975 and 1995 despite few changes in the incidences of cancer. *Journal of the National Cancer Institute*, 6/16/99

New American College of Gastroenterology guidelines say the use of over-the-counter medications and antacids is an appropriate initial approach to therapy in some patients with mild forms of gastroesophageal reflux disease. *Reuters Health*, 6/16/99

A preliminary study shows that manic-depressive patients given omega-3 fatty acid had significantly longer remissions and performed better on four symptom-severity scales than those in the placebo group. *Archives of General Psychiatry*, 5/99

Women who exercise vigorously while trying to quit smoking are twice as likely to quit as those who do not work out regularly, researchers at The Miriam Hospital in Providence, RI, reported after studying 218 women in a 12-week antismoking program. *Archives of Internal Medicine*, 6/99

A third of American men participating in an Opinion Research Corp survey commissioned by *Men's Health* magazine and CNN say they would shun medical care even if they had symptoms of a heart attack. Thirty-four percent said they would not go to a doctor for chest pain and 37% said they would not go if they experienced shortness of breath. *Reuters Health*, 6/14/99

Patients treated with tissue plasminogen activator within 3 hours of a stroke caused by a blood clot in the brain are less likely to be severely disabled a year later, according to researchers at Long Island Jewish Medical Center and eight other hospitals. *New England Journal of Medicine*, 6/10/99

Aggressive reduction in cholesterol levels after treatment for coronary artery bypass graft surgery improves clinical and angiographic outcomes in both diabetic and nondiabetic patients. *Diabetes*, 6/99

A study of 514 asthmatics shows that adding the bronchodilator salmeterol to therapy with inhaled beclomethasone is more effective than doubling the beclomethasone dosage. *Allergy and Asthma Proceedings*, 5/6/99

TMA members appointed to TWU Board of Regents

Houston internist Carlos R. Hamilton, Jr, MD, and Dallas psychiatrist Linda R.L. Hughes, MD, are among four new regents recently appointed to the Texas Woman's University (TWU) Board of Regents by Gov George W. Bush.

Carlos R. Hamilton, Jr, MD Linda R.L. Hughes, MD

Both physicians were quick to proudly recognize TWU's achievements. The university is "a major educational force in the health care fields in Texas," Dr Hamilton said.

With its main campus in Denton, TWU is not only the nation's largest university primarily for women but also the state's largest producer of health care professionals. About half of its 9,400 students major in health sciences.

Though TWU is not a nursing school, the TWU College of Nursing is among the largest in the country. Programs in occupational therapy, physical therapy, dental hygiene, health studies, kinesiology, health care administration, and nutrition and food sciences also draw future health care professionals to the school.

"We're also doing some research on women's health, which is an area of great importance," Dr Hughes said. The TWU Center for Research on Women's Health is using TWU's built-in female population for longitudinal and short-term research in areas such as cardiovascular health, osteoporosis, nutrition, breast cancer, and teen birth rates.

Dr Hamilton, who will serve 2 years of an unexpired term on the board, is president of the Harris County Medical Society and a member of the Texas Medical Association House of Delegates and the Texas Academy of Internal Medicine Board of Directors. Dr Hughes, whose father and grandfather also served TWU as business manager and comptroller, respectively, will serve 6 years on the board. She is treasurer of The University of Texas Southwestern Medical School Alumni Association and a member of the American Medical Women's Association, the Dallas County Medical Society, and the Dallas Women's Foundation Board.

The two new regents' first goal will be finding a new president for TWU, which they hope to accomplish sometime this summer. ★

TMAF benefit raises public heath funds

The more than 400 Texas Medical Association members, their spouses, and corporate guests who spent a New York night at TMA Foundation's (TMAF's) sixth annual benefit raised $124,000 for TMAF and the many TMA, county medical society, and alliance programs it funds.

Hosted by cochairs Dr and Mrs Dennis J. Factor, of Dallas, "New York Nights" was held in conjunction with TexMed '99 in Dallas. Newly elected TMAF Board of Trustees President Mark Kubala, MD, provided the highlight of the evening by presenting outgoing president Joseph Abell, MD, with a recognition award for 2 years of outstanding service in office.

"New York Nights" sponsors included:

- *Wall Street Sponsors:* Tenet Healthsystem-Texas Region and Tenet Healthcare Foundation.
- *Broadway Sponsors:* Humana Health Plans of Texas, ProMedCo Management Company, and Texas Medical Liability Trust.
- *Fifth Avenue Sponsors:* American Airlines, Baylor Health Care System, Baylor Health Care System Foundation, Dr and Mrs Dennis J. Factor, Fulbright & Jaworski LLP, Harris County Medical Society, Huguley Health System, Kelsey-Seybold Clinic, Luther King Capital Management, Prudential Group Life & Disability Insurance, and Rudd & Wisdom, Inc.

Mark your calendar for the seventh annual TMAF benefit scheduled for May 26 during TexMed 2000 in San Antonio! ★

Robert Wilson of J.J. Jowdy Photography

Attendees of Texas Medical Association Foundation's "New York Nights" benefit were treated to the elegant art-deco ambience of one of Manhattan's most fashionable nightclubs and the smooth sounds of internationally known musician Larry "T-Byrd" Gordon and his 16-piece show band.

TECAP takes off in Waco

Texas Medical Association's Texas Environment of Care Assessment Program (TECAP), the highly regarded product of TMA's Medical Directors' Forum, was field-tested in Waco during May. TECAP staff provided office site and medical record reviews in McLennan and surrounding counties for Providence Health Alliance, an independent practice association. With help from a $3,000 grant from the Texas Medical Foundation, TECAP staff field-tested the project in approximately 120 physicians' offices.

"The surveys went very well," said Lisa Harmon, RN, director of TMA's Science and Quality Department. "More than half the physicians we encountered remarked that they think TECAP is a great concept. They are all for TMA performing the reviews instead of multiple insurance companies coming into their offices."

To comply with National Committee for Quality Assurance (NCQA) and Texas Department of Insurance (TDI) credentialing standards, managed care plans are required to inspect the offices and a sample of medical records of their participating physicians. Many physicians sign contracts with multiple plans, so they must undergo numerous inspections that review essentially the same issues.

TMA found a solution to this redundancy with TECAP. Through its Medical Directors' Forum, TMA developed a unified, statewide office inspection tool in which office site and medical record review information is gathered using a single protocol. This tool reflects what the plans and TMA members think is a good standard, and outlines a process that is fair, effective, and comprehensive in applying the instrument. The TECAP instrument satisfies all NCQA, Texas Department of Health, and TDI office site and medical record review requirements, and offers consistency and uniformity throughout the review process. Registered nurses trained in quality improvement practices conduct the surveys.

For more information, call Lisa Harmon at (800) 880-1300, ext 1400, or (512) 370-1400; or e-mail tecap@texmed.org. ★

C O N N E C T T O T M A

HotLines

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Impaired physicians (800) 880-1640
Call this 24-hour hotline to report information concerning physicians who may be abusing alcohol or other drugs, or who may be chemically addicted, psychiatrically impaired, or have other problems. All calls are confidential.

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The Texas Medical Association Insurance Trust offers life, health, disability, office overhead, personal accident, and other insurance plans and products to TMA members, their families, and office staffs.

Loans (800) 880-2828
TMA offers qualified medical students and residents low-interest loans. Call for general requirements and application procedures.

TEXPAC (800) 880-1300, ext 1362
The TMA Political Action Committee speaks on behalf of physicians through grassroots involvement, personal relationships with elected officials, and political campaign participation and contributions.

TMA Physician Services (800) 523-8776
TMA Physician Services delivers physicians and physician organizations an array of products and services to help them succeed in the changing medical marketplace.

Use the following prefixes plus @texmed.org to e-mail for TMA resources.

General Information	info
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Interspecialty Society Committee	isc
Medical Education	meded
Member Services	memberservices
Meeting Management	meetings
Physician Oncology Education Program	poep
Sneak Preview	sneakpreview
Specialty Societies	ssms
TMA Alliance	tmaa
TMA Bookstore	bookstore
TMA Library	tma_library
TMA Physician Services	physician_services

MedBytes

August is synonymous with "back to school," so this month's "MedBytes" provides some online resources for continuing medical education (CME).

Medscape's CME center

At www.medscape.com/Home/CMEcenter/CMECenter.html, Medscape offers both free and fee-based Category I continuing education activities. The free programs involve learning modules developed by Medscape under educational grants and accredited by a sponsor approved by the Accreditation Council for Continuing Medical Education (ACCME). The fee-based program, which costs $50 for unlimited access over 12 months, is available for select medical journal articles developed by Medscape and other publishers and accredited by an ACCME-approved sponsor. More than 120 hours are available in all specialties and topics.

Doctor's Guide to Medical Conferences & Meetings

The site at www.pslgroup.com/medconf.htm allows its 700,000 visitors a month to search for conferences by location, date, or keyword.

The Interactive Patient

Marshall University School of Medicine's interactive patient site at medicus.marshall.edu/medicus.htm is a teaching tool for physicians, residents, and medical students. The site offers a case with a chief complaint to the user who then has to interact with the patient requesting additional history, performing a physical exam, and reviewing laboratory data and x-rays. After the workup, the user submits a diagnosis and a treatment plan to the system. All submitted answers will be evaluated, and feedback will be provided. This activity, which requires an administrative fee of $15, is good for 1 hour in Category 1 credit toward the American Medical Association Physician's Recognition Award.

HealthGate CME courses

The HealthGate site at www.healthgate.com/cme offers a list of CME coursework from the Boston University School of Medicine. One credit costs $8, and those who earn a passing grade of 70% or better will receive a certificate of credit within 6 weeks.

HELIX

HELIX, the Healthcare Education Learning & Information Exchange, provides interactive CME at www.helix.com. Developed by Glaxo Wellcome, the site contains continuing education for physicians, nurses, and pharmacists.

SearchCME

The "quickest search engine for continuing medical education"at searchcme.com contains CME information on more than 5,000 medical conferences. Search for a medical conference by medical specialty, geographic location, and date. Most medical conferences listed offer CME credit toward the American Medical Association Physician's Recognition Award.

TMA's CME resources

In the "Education/CME" section of Texas Medical Association's Web site at www.texmed.org, the TMA Library offers online CME catalogs, a searchable index for CME opportunities in Texas, and audiotapes-for-loan subscription programs. Medical ethics,Physician Oncology Education Program, TMA Stroke Project, and TMA Committee on Physician Health and Rehabilitation CME courses also are housed in this area.

MedBytes is a quick look at new, or newly discovered, Web sites of interest to Texas physicians. The column also highlights features of the TMA Web site at www.texmed.org. If you know of some cool medical sites or have questions about how to use the TMA Web site, e-mail larry_b@texmed.org. Publication of information about Web sites in this column is not to be considered an endorsement or approval by the Texas Medical Association of the sites or sponsors, or of any products or services involved.

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TMA physician directory available to order

The Texas Medical Association 1999–2000 Physician Directory and Resource Guide is available for physician members who have not ordered their copies or who need additional copies.

The directory contains alphabetical and geographical listings of more than 30,000 physicians licensed in Texas, including specialties and practice types, telephone numbers, addresses, and fax numbers, if available. It also includes related health organizations, Texas medical schools, and hotline numbers, and a complete TMA reference section.

TMA members receive one free copy by request. Extra copies for physician members cost $25 each. Cost for nonprofit organizations is $60 each for up to 20 copies and $50 each for more than 20 copies. Cost for all others is $100. Texas sales tax (8.25%) should be added to all orders, unless a Texas certificate of exemption from sales tax is provided.

To order, call TMA at (800) 880-1300, ext 1310, or (512) 370-1310. ★

Prescription advertising produces side effects

Drugmakers' advertising of prescription medications directly to consumers has produced both positive and negative side effects for drug companies, according to a recent survey conducted by *Time* and *Health* magazines. A June Associated Press report says ads have prompted consumers to ask their physicians to prescribe certain drugs, which has driven up pharmaceutical sales. But physicians may prescribe rival drugs they prefer over the advertised drugs.

The study of 1,000 adults found that a third of consumers who saw a drug ad have talked to their physicians about it. Of those consumers, about one in four received a prescription from the physicians, but not necessarily for the drug they requested. ★

TDH survey examines youth tobacco use

Texas kids annually smoke more than 15 million packs of cigarettes worth $39 million, according to a Texas Department of Health (TDH) survey. Though it is illegal for anyone under age 18 to buy, possess, or use tobacco products, Texas kids spend $27.6 million on Marlboro products, $3.7 million on Newport products, and $3.5 million on Camel products each year, according to the survey that focused on smokers in grades 6 through 12.

"Marlboro is the most heavily advertised brand," said Texas Commissioner of Health William R. Archer, MD. "That advertising is obviously working on our youth. Parents and kids need to be more concerned about the health hazards of smoking and furious over the amount of money tobacco companies are making off our children."

Other TDH Texas Youth Tobacco Survey findings show that:

- Approximately 404,375 public middle and high school students under age 18 smoked at least a cigarette a day during the past 30 days.
- A conservative estimate of the average number of cigarettes consumed each month by Texas youth under age 18 is 64 cigarettes for each smoker.
- Marlboro is the brand of choice among white (73%) and Hispanic (74%) students. Newport is the leading brand among African Americans (48%).

For more information, contact TDH's Office of Tobacco Prevention and Control at (800) 345-8647 or (512) 458-7402. For a listing of the state's certified tobacco cessation instructors, consult TDH's youth-oriented Web site titled "Don't Get Burned by Tobacco" at www.dontgetburned.com. ★

CME conference balances challenges

More than 100 continuing medical education (CME) planners, including physician CME committee chairs, attended TMA's annual Texas CME sponsor conference in June in Austin.

Titled "Balancing Challenges in CME" and jointly sponsored by TMA and the Texas Alliance for Continuing Medical Education, the conference highlighted alternative health care practices, the Accreditation Council for Continuing Medical Education's (ACCME's) new system of accreditation, American Medical Association Physician's Recognition Award changes, and practical ideas for developing a successful CME program.

Featured speakers included Martin Kantrowitz, MD, director of the Center for the Understanding of Healing in Albuquerque, NM; Dennis Wentz, MD, director of AMA's Division of CME in Chicago; Stephen Biddle, MEd, director of Continuing Education at the Annenberg Center for Health Sciences in Rancho Mirage, Calif; and Jim Leist, EdD, director of Accreditation Development for ACCME in Winston-Salem, NC.

TMA is recognized by the ACCME as an intrastate accreditor of CME sponsors. Nearly 50 hospitals and institutions are accredited by TMA. For more information, call TMA's Continuing Medical Education Department at (800) 880-1300, ext 1446, or (512) 370-1446; or e-mail billie_d@texmed.org. ★

Discovery campaign enhances Baylor research

Texas Medical Center's largest fundraising campaign ever will support Baylor College of Medicine's endowment and key programs on the cutting edge of medical research and technology. The $500 million "Investment in Discovery Campaign" targets faculty development, student support, research infrastructure, and programmatic initiatives to advance medical cures. ★

Speakers added to fall conference lineup

National experts in reimbursement and ethics will address attendees at Texas Medical Association's 1999 Fall Conference: Turning Points in Medicine, Saturday, September 18, at the Renaissance Austin Hotel.

John M. Eisenberg, MD, director of the Agency for Health Care Policy and Research in Rockville, Md, will discuss payment issues during the general session, while Texas' own Robert M. Tenery, Jr, MD, immediate past chair of the American Medical Association Council on Ethical and Judicial Affairs, will focus on medical ethics conflicts and issues during the "dawn duster" session that begins at 7:45 am on Saturday. The conference also includes a luncheon hosted by the Texas Medical Liability Trust and a legislative review session, at which members of the Texas Legislature will be recognized with "Best of Texas Medicine" awards.

To register or to obtain more information, call Amy Edwards, TMA special services, at (800) 880-1300, ext 1346, or (512) 370-1346; or e-mail amy_e@texmed.org. ★

TMC plans $418 million construction projects

Imagine the Texas Medical Center (TMC) increasing its size by 50% over the next 15 years. The TMC board has done just that with the unveiling of $418 million in new construction projects. These projects include:

- A 425,000-square-foot research building for The University of Texas M.D. Anderson Cancer Center that will cost $137.2 million and be completed by 2002.
- A Baylor College of Medicine research building.
- A new amenities building surrounded by open space on the K-Lot at the corner of Bertner and Moursund.
- As many as 7,800 new parking spaces and an $11 million computer system upgrade of all existing TMC parking lots.

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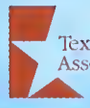

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Antitrust defense

Organized medicine secures another major legislative victory

The 76th Texas Legislature was not supposed to be one that would break new ground in managed care reform. After all, the previous legislature 2 years before had passed an enormous body of sweeping managed care reforms — including the precedent-setting, first-in-the-nation managed care liability bill. ➤➤

By Ken Ortolon, Associate editor

Going into the 1999 session, the Texas Medical Association had set its sights on a much more modest agenda of technical reforms. Most were aimed at the operational side of health maintenance organizations (HMOs) — prompt payment for physicians, HMO solvency, limits on financial risks HMOs can pass down to physician networks, and the outlawing of so-called "silent PPOs."

But in late February, acting in response to an emerging pattern of abuse by managed care plans, organized medicine altered its agenda. Just days before the legislature's bill-filing deadline in mid-March, Sen Chris Harris (R-Arlington) and Rep John Smithee (R-Amarillo) introduced legislation to allow independent physicians to band together to negotiate contract provisions with HMOs and other managed care plans.

Despite an immediate wave of protest from health plans and their business allies, the bill garnered overwhelming legislative support and, for the second time in 2 years, lawmakers approved landmark managed care legislation that once again put Texas in the forefront of protecting patients' rights.

Late in the day on June 20, the last possible day to do so, Gov George W. Bush signed Senate Bill 1468 into law. "This new legislation gives the attorney general of Texas significant new authority and oversight to make sure doctors and patients are treated fairly as the health care market changes," the governor said in signing the bill. "It provides a check and balance to make sure that HMOs are not able to unfairly use their market power to dictate the quality of patient care."

Getting a late start

To use a term popular with TMA lobbyists, SB 1468, the Physician Negotiation Bill, wasn't even on organized medicine's radar screen when the legislature convened in January. "We were on a legislative path that would have let us deal piecemeal with some of the technical aspects of physician contracts with HMOs — physician referral lists, pharmacy formularies, and prompt payment," said Robert W. Sloane, Jr, MD, chair of TMA's Council on Legislation.

At the same time, TMA physician leaders, lobbyists, and policy staff were grappling with the problem of multibillion-dollar health insurance corporations presenting individual physicians with "take it or leave it" contracts with little or no room for negotiation. The issue came to a head last fall when Genesis Physicians Practice Association, a large, multispecialty physician group in Dallas, attempted to negotiate changes in its physicians' contracts with Aetna US Healthcare. Not only did Aetna refuse to alter its business practices, it forced the Genesis physicians out of all of its managed care plans and threatened federal antitrust action, claiming the physicians had illegally colluded in their discussions with Aetna.

Genesis was not the first physician group in Texas to face the threat of antitrust action. Dr Sloane says it was evident the health plans were willing to employ the antitrust threat to force physicians to accept contracts that the doctors felt were antipatient.

"There were at least two clear examples out there showing that some of the managed care companies were willing to use this devilish tactic to force doctors to remain silent on these contracts," Dr Sloane said. "It's a tactic that costs the managed care plans nothing. It instantly puts the federal government against the practitioner. The health plans sit on the sideline and let the government prosecute."

TMA lobbyist Connie Barron says the problem was not unique to Texas. "In our discussions with the American Medical Association over the Genesis situation, we realized there was a pattern emerging nationwide and that we were likely to see more of it in Texas," she said.

Enter the AMA

While legislation to provide some antitrust relief for physicians at the national level was already being considered, the outlook for quick action on it was not good. And, TMA lobbyists had no solution for addressing the issue at the state level because it was federal antitrust law that prevented independent physicians from discussing any contract provisions with their colleagues. Then, a piece of model legislation developed by the AMA landed on Ms Barron's desk.

The AMA bill involved a "state action doctrine" and was based on legislation passed in the state of Washington in 1991. The state action doctrine does not exempt physicians from federal antitrust law but provides a defense against antitrust allegations by having the state supervise any negotiations to ensure consumers are not harmed by price-fixing or other anticompetitive activities.

> "This new legislation gives the attorney general of Texas significant new authority and oversight to make sure doctors and patients are treated fairly as the health care market changes."

Becky Cerny, AMA director of state legislation, says the impetus to develop the model bill came from a resolution adopted at the AMA House of Delegates interim meeting in 1998. The resolution asked AMA to determine the feasibility of model state legislation to provide antitrust relief. Ms Cerny says AMA determined state legislation was feasible after it reviewed the Washington law. A model bill was drafted in January and sent to state medical societies in February.

"Even as we were trying to develop a consensus on how to approach this issue, we were presented with the AMA's state action doctrine model," said Kim Ross, TMA vice president for public policy. "We very quickly vetted the idea

All articles in *Texas Medicine* that mention Texas Medical Association's stance on state legislation are defined as "legislative advertising," according to Texas Govt Code Ann §305.027. That law requires disclosure of the name and address of the person who contracts with the printer to publish the legislative advertising in *Texas Medicine:* Louis J. Goodman, PhD, Executive Vice President, TMA, 401 W 15th St, Austin, TX 78701.

to see if we were on solid ground and whether it would work."

It did, and the model legislation was presented to the TMA Council on Legislation, which approved introducing the bill. "This opened the door to being able to negotiate whole contracts right where the rubber meets the road rather than trying to address problems piecemeal in the legislative process every time a problem comes up," Dr Sloane said.

talking to HMOs about patient care issues," he continued. "When those two developments were coupled together, I felt we needed to do something to try to keep the balance, and I felt we could do it here in Texas with some oversight by the attorney general."

Mr Smithee says the bill allows doctors to talk to each other about quality of care issues and, in some cases, communicate those concerns to the HMOs.

health plans about constructive ways to control health care costs and still provide quality care to patients," Ms Barron said.

> "If doctors are in a position to negotiate quality care, it can't help but be an improvement for the patient."

Lining up support

Mr Ross says the model legislation came to TMA's attention on or about February 20, leaving little time to get actual legislative language drafted and introduced before the bill-filing deadline on March 12. Senator Harris and Representative Smithee readily agreed to sponsor the bill, and it was filed in both the House and Senate, barely beating the deadline.

Senator Harris says he took on the issue because of concerns expressed to him by his personal physician about the problems doctors face trying to deliver quality patient care. "The problem you have now is that some clerk at an HMO is making life-and-death decisions for patients and, as a result, people are not getting the quality of care to which they are entitled," Senator Harris said. "If doctors are in a position to negotiate quality care, it can't help but be an improvement for the patient."

Representative Smithee said he also was concerned by "disturbing" changes in the HMO marketplace over the past few years. "One is the accumulation by one or two HMOs of very large market shares in certain areas," he said. "By virtue of merger and acquisition, they've gained a very dominant role in health care decisions.

"The other issue has been the investigations of doctors by the Federal Trade Commission and the US Department of Justice for antitrust violations for simply

'The sky is falling'

As soon as the bill was filed, the Texas Association of Health Plans (TAHP) and its business allies screamed that they had been blindsided by TMA. They attempted to tag the legislation as a "doctor union" bill and trotted out the same "sky is falling" arguments about increased health care premiums that they had used unsuccessfully against the 1995 and 1997 managed care reforms.

"The insurance industry relied heavily on provoking a knee-jerk reaction that this was a union bill that was going to allow physicians to unionize, strike, and boycott, and that it was going to raise health care costs, which got the business community into it," Ms Barron said. "Killing the bill was its No. 1 agenda item this session."

The Texas Association of Business and Chambers of Commerce (TABCC) weighed in on the side of the health plans, faxing alerts to its members, running a massive telephone bank operation to drum up opposition to the bill, and running a statewide radio advertising campaign against it. The TABCC campaign was rife with misinformation about the bill.

"They gave absolutely none of the factual information that these negotiations would be voluntary, that they were nonbinding, and that the bill would allow unfettered communication so doctors could talk to each other and to

Deflecting the opposition

The doctor union arguments didn't carry much weight because the bill clearly did not authorize unions and expressly prohibited strikes and boycotts. On top of that, Ms Cerny and other AMA policy experts spent considerable time in Austin helping TMA leaders and lobbyists fully explain the measure to lawmakers and business leaders. "Our role was to explain the impetus for the legislation, talk more specifically about the national problem, and sort through the sticky points of the bill that people didn't seem to grasp or understand," she said.

Randolph D. Smoak, Jr, MD, chair of AMA's Board of Trustees, joined Texas doctors and the bill sponsors at a March 11 news conference announcing the filing of the bill. And, AMA Board of Trustees member Donald J. Palmisano, MD, testified in favor of the bill at House Insurance Committee hearings.

Possibly the most damaging argument raised against the bill was another element of misinformation. Opponents contended it would allow physicians to opt out of plans that cater to low-income and elderly Texans — such as Medicaid and Medicare HMOs — and, therefore, "cherry pick" the patients they want to see. That argument revolved around the so-called "tied products" clause found in the contract Aetna had used against the Genesis physicians.

Separate legislation to outlaw such clauses in HMO contracts with physicians was filed, but a tied products clause was not even mentioned in SB 1468. While tied products might have been open to negotiation under the bill, the argument was disingenuous because Aetna is the only major HMO in the state currently enforcing a tied products clause and it does not offer Medicaid or Medicare HMO plans in Texas.

Still, some of the bill's opponents attempted to convince liberal and minority lawmakers that it would harm their low-income and elderly constituents.

Despite intense opposition and a late start, the bill began to advance as the leg-

islative session entered its closing weeks. Senator Harris says the HMOs' and business groups' arguments did not sway lawmakers because they were not being honest about the bill's potential impact. "It caught up with them," he said.

With persistent and persuasive arguments from Senator Harris, the bill cleared the Senate Economic Development Committee. Senator Harris then went to his longtime friend and confidante Lt Gov Rick Perry and recruited his support.

"When the lieutenant governor weighed in, the Red Sea parted," explained Mr Ross. "Senator Harris was able to get his bill to the full Senate where he is virtually without peer in floor debate." With the lieutenant governor's support, it was overwhelmingly approved by the Senate and sent to the House for deliberation. Only two senators voted against considering the bill.

Opposition intensified in the House Insurance Committee, which Representative Smithee chairs. At one point, the committee considered removing provisions allowing physicians to negotiate fees. But Representative Smithee says fees are a legitimate quality of care issue.

"I think most of us who worked on this bill in the House believed this legislation should not be used simply as a way to unrealistically elevate fees above what the market would dictate, but rather that it be a way to police quality of care issues," he said. "But whether an HMO is paying adequate fees to get qualified doctors into its plan is a quality of care issue that you really can't hide from and that really needed to be addressed."

The fee language stayed in, although strict limits on when fees can be discussed were adopted. And, after language was added to limit the number of physicians in any one community that could band together and to ensure that "cherry picking" would not be allowed, the bill easily passed that committee in mid-May.

Setting the calendar

The great western folklorist Will Rogers was fond of saying, "I never met a man I didn't like." Texas lawmakers are fond of saying, "Will Rogers never met the House Calendars Committee." With SB 1468 out of the House Insurance Committee, the Calendars Committee became the battleground.

The Calendars Committee can make or break any bill because it is charged with scheduling every bill for debate on the House floor. Leave a bill off the calendar and it dies. TAHP and TABCC waged an all-out campaign to keep SB 1468 bottled up in the Calendars Committee until the end of the session. Despite their professional phone bank operation and misinformation campaign, grassroots lobbying by physicians and TMA Alliance members won the day. Hundreds of phone calls, faxes, and e-mails poured into representatives' offices urging the Calendars Committee to schedule the bill and House members to approve it.

On the last possible day that House rules would allow the bill to be debated, it was finally posted on the House Major State Calendar — the very last bill on the calendar that day.

But the fight wasn't over. Getting the bill on the calendar was one thing, getting it up for debate was another. Bill opponents spent most of the day "chubbing" it. "Chubbing" is the process of drawing out debate on other bills with questions, amendments, or wordy remarks in opposition to delay debate on another measure. Because each bill, amendment, or motion gets an allotted amount of time for debate, opponents were able to drag out debate on bills posted higher on the calendar, use up all allotted time, and stall action on SB 1468.

It almost worked. If opponents could have kept the "chubbing" up a few hours longer, SB 1468 would have died for lack of time.

"Because the bill was last on the Major State Calendar, there was a good chance that people could talk it to death, time would run out, and this bill would never get up for debate," said Rep Kyle Janek, MD, (R-Houston), who joined Representative Smithee, Rep Craig Eiland (D-Galveston), and others as House floor leaders supporting SB 1468.

> "I think most of us who worked on this bill in the House believed this legislation should not be used simply as a way to unrealistically elevate fees above what the market would dictate, but rather that it be a way to police quality of care issues."

Representative Janek says it appeared opponents of the Physician Negotiation Bill might succeed until a couple of major bills higher on the calendar unexpectedly were struck down on points of order. Cutting off debate on those bills bought supporters the time they needed.

Making the point

Still, floor debate on SB 1468 took 3 hours and was intense. "It was a relief finally for us to get it to the floor and be able to get the members' attention, to explain to them what the bill did and what it did not do, and to alleviate the fears that had been fanned by the HMO industry," Representative Janek said.

When the vote finally came, SB 1468 passed the House by the lopsided vote of 119-20. The measure was sent back to the Senate where — with just 3 days left in the legislative session — Senator Harris easily won Senate concurrence with the House version.

TAHP and TABCC made a final pitch to get Governor Bush to veto the bill, but again physicians and alliance members rallied in its support, flooding the governor's office with calls, faxes, and e-mails urging him to sign it. Dr Sloane says he expects the health plans to

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challenge the bill in court once it takes effect.

Shifting arenas

With the success of the Texas legislation, Ms Cerny says several other states already are looking at enacting similar laws.

Meanwhile, opponents of the bill already are looking to use the Texas law to block action on the congressional level to give physicians across the country the ability to jointly negotiate with HMOs. The health plans say Texas doctors never intended to use SB 1468 for negotiations, but merely pushed it to build support for legislation by US Rep Tom Campbell (R-Calif) that would give physicians more traditional collective bargaining rights. TMA, however, believes the approach represented by the Physician Negotiation Bill is a more appropriate mechanism to allow physicians to advocate against antipatient HMO contracts than amending federal labor law.

And, Senator Harris believes SB 1468 will be used frequently by physicians to combat contracts that compromise quality patient care.

"The HMOs have a decision to make," he said. "They can start having full disclosure with the doctors, having true negotiations with them, addressing quality care, and solving problems for themselves. Or, they can continue to make it a 'take it or leave it' situation and continue the antitrust threats as a number of them have historically done. If they take the last option, I think you will see a huge proliferation of the use of this bill." ★

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CHOOSING ONE

Physicians can empower patients to quit unhealthy behaviors

By Johanna Franke, Associate editor

AHO

Because heart disease, cancer, and stroke — the leading causes of death in Texas — can be traced to unhealthy behaviors such as smoking, lack of exercise, bad diets, substance abuse, and not following medication schedules, many health groups have recognized the importance of physicians counseling patients to change their ways. Unfortunately, most physicians have not.

Studies show physicians can positively impact patients' health risk behaviors and that their counseling is cost-effective (1). And patients would rather receive advice on health risk behaviors from their physicians than from local hospitals, the government, the media, or employers, according to a 1993 national survey (2).

But lack of time, reimbursement, resources, and counseling skills often keep physicians from discussing health risk behaviors with patients, says Pam Mathison, RN, MA, a nurse consultant for the Texas Department of Health's (TDH's) Adult Health Program. "Physicians often think they need to do it all," Ms Mathison said. "They only have 5 to 10 minutes per patient, and they tend to focus on the health problems that exist rather than the whole picture."

In a way, we have become our own worst enemies. We've learned to improve water supplies, refrigerate food, develop vaccines, and alleviate overcrowding, resulting in lower mortality rates for infectious, acute diseases, but our new and improved lifestyles have allowed chronic diseases to move up the charts. In addition to heart disease, cancer, and stroke, AIDS and other sexually transmitted diseases caused by risky behavior are quickly rising in the mortality rankings.

In 1990, more than 875,000 deaths in the United States were considered attributable to health risk behaviors, representing more than 40% of deaths related to external (nongenetic) causes (1). Groups such as the US Preventive Services Task Force have made efforts to turn this trend around. In 1989, after exhaustive research on the efficacy and cost-effectiveness of various preventive services, the task force found that useful interventions addressing lifestyle choices such as smoking, harmful nutrition, physical inactivity, alcohol abuse, and unsafe sex practices could have greater impact on patients' health than secondary prevention measures like screening tests. The task force emphasized that physicians and other health care professionals should be selective in providing preventive services and should individualize these services according to assessments of patients' risks.

Initiatives to address chronic disease prevention, such as Put Prevention into Practice (PPIP), followed. The PPIP campaign was created in 1994 by the US Department of Health and Human Services' Office of Disease Prevention and Health Promotion, which is now housed in the US Agency for Health Care Policy and Research. But even with the research findings and resources, most physicians still have not recognized the importance of their role in empowering patients to change unhealthy behaviors.

Physician responsibility

What is causing physicians to hold back on counseling their patients? Besides the factors mentioned by Ms Mathison, attitude and recognition problems of physicians also impede behavior counseling, says Billy U. Philips, Jr, PhD, professor in the Department of Preventive Medicine and Community Health at The University of Texas Medical Branch at Galveston. "Physicians must have the attitude that patient counseling and guidance is a vital role, and they must recognize that the power in being a doctor is the ability to influence patients in matters pertaining to their health," Dr Philips said.

Philip Huang, MD, MPH, chief of TDH's Bureau of Disease and Injury Prevention, has a simple method for influencing a patient's behavior. When he and a patient agree on a date for the patient to quit smoking, Dr Huang makes sure they seal the agreement with a handshake. "Several patients who have quit smoking have said to me, 'Well, we shook hands on it, so I felt committed to quit.'"

TMA Advantage:
Watch Out for WATCH

See the September issue of *Texas Medicine* for information on Texas Medical Association's new cardiovascular disease and stroke prevention program for 1999–2001, the WATCH (weight, activity, tobacco, cholesterol, and hypertension) Project.

But most physicians don't get positive feedback, so they don't feel effective, says Nell Gottlieb, PhD, professor and coordinator of health education programs at The University of Texas (UT) at Austin and professor of behavioral science at the UT-Houston School of Public Health. "Physicians believe they're effective counselors — they have high self-efficacy — but they don't believe that patients are going to follow through."

This lack of follow-through feeds a physician's belief that a patient cannot be helped, which is another barrier to health risk counseling, says Terry A. Rustin, MD, medical director of the Dual Disorders Programs at the Mental Health and Mental Retardation Authority of Harris County. This belief, combined with a physician's "own compulsive need to solve people's problems," often leads to a frustrated physician providing little, if any, counseling, Dr Rustin says.

"A physician's attitude should not be one of being responsible for changing a patient's behavior," Dr Philips said. "The patient is responsible for changing patient behavior. Doctors get in trouble when they own it, instead of remembering that their job is to provide information and motivation." But different patients in different situations will need this information and motivation presented to them in different ways and at different times, says J. Gregory Carroll, PhD, director of the Bayer Institute for Health Care Communication in West Haven, Conn.

A workshop produced by Bayer, "Choices and Changes: Clinician Influence and Patient Action," defines the two most important dimensions on which patient behavior change is based — conviction and confidence. "You can be highly convinced to make a behavior change but very low in confidence, and vice versa," Dr Carroll said. The most common mistake physicians make is assuming all patients are both highly convinced they need to make a change and highly confident they can actually make it.

"The real task for the clinician from a communication standpoint is to very quickly assess the amount of conviction and confidence in a patient in less than a minute with a few simple questions," Dr Carroll said.

Patience with patients

By using the questions incorporated in the stages-of-change behavior model, along with patience and persistence, physicians can help their patients move toward the ideal combination of conviction and confidence needed to change their behavior, Dr Philips says.

His "Two P Approach" may take some time. "For example, it takes 7 to 11 tries before a smoker will ultimately succeed in stopping, and those tries may occur over as long as a 3- to 5-year period. That's the 'Patience' part. The 'Persistence' part comes in each time you encounter that patient — you have to reinforce the message. It's classic behavioral conditioning," he said.

"Physicians don't get much feedback in terms of the numbers of patients who have changed their behaviors, so it makes a real difference when physicians think of their own successes in terms of moving patients from one stage to another — not just the final behavioral change," Dr Gottlieb said.

> "Physicians must have the attitude that patient counseling and guidance is a vital role, and they must recognize that the power in being a doctor is the ability to influence patients in matters pertaining to their health."

The Bayer workshop applies the stages of change not only to patient thinking but also to clinician thinking through the following example:

- *Precontemplation*: "It is not my role to try to convince my patients to change unless they bring it up, even when I know they are engaging in dangerous or potentially life-threatening behaviors."

Common mistakes during health risk behavior counseling

Terry A. Rustin, MD, medical director of the Dual Disorders Programs at the Mental Health and Mental Retardation Authority of Harris County, teaches students at The University of Texas-Houston Health Science Center how to help patients change their alcohol and drug use and other harmful behaviors. He offers six common pitfalls physicians stumble into while trying to encourage patients to change their ways.

***Fatalism*: "Nothing we can do or say helps these wretches."**

***Moralizing*: "Aren't you ashamed of what you've done?"**

***Parenting*: "Now, if you'd just done what I said, you wouldn't be in this situation."**

***Denial*: "Mr Smith can't be an alcoholic — he's the president of the company!"**

***Ignorance*: "Take this Valium when you get tense; it's much safer than drinking."**

***Naiveté*: "Okay, you've promised not to drink any more, so I'm satisfied."**

- *Contemplation*: "I'm concerned about my patients not adhering to the suggested regimen, but I'm not sure what to do or how to go about changing things. I don't think I have time anyway."
- *Preparation*: "I need to get more skill in this area. What's out there?"
- *Action*: "Mr Jones, we need to talk about your eating habits and the impact on your diabetes. Are you ready to do that now?"
- *Maintenance*: "Sometimes, I get so busy or behind that I don't feel I have time to do the job I want to. I have to remind myself that working with patients to change their behavior is vital to their health."

These same stages can be applied to a patient's readiness to make a change. Patients, though they may seem put off by constant reminders about their unhealthy behaviors (see "Common Mistakes During Health Risk Behavior Counseling," p 37), depend on their physicians to counsel them, says John Lewis, MD, JD, a Houston ophthalmologist who teaches the Bayer workshop to groups around the state.

"Basically, our job is to be trusted and to translate and communicate," said Dr Lewis, a professor at the University of Houston College of Optometry. "Bayer doesn't even use the word 'compliance.' Bayer says that if you've educated the patient, and he or she has the information, then that patient has the absolute right to choose what to do."

Physical activity counseling tailored to a client's stage of change

Precontemplation

Precontemplators may realize that change is indicated, but are not willing to consider altering their health behaviors (eg, "I've never exercised and I have no desire to start now"). They comprise 10% of the general population.

Goal: **Encourage the patient to consider beginning an activity program.**

How?

- **Summarize the benefits of physical activity.**
- **Relate the benefits to personal health status.**
- **Have the patient list personal reasons to be active.**
- **Have the patient identify barriers to physical activity.**
- **Give clear advice to consider beginning a physical activity program.**

Contemplation

Contemplators know they need to be active. They are thinking about making a health behavior change, but may not have the skills, knowledge, or incentive to do so (eg, "I've been wanting to start an exercise program, but I just can't find the time"). Contemplators comprise 50% of the general population.

Goal: **Make a specific plan for beginning an activity program.**

How?

- **Give clear advice to begin a physical activity program in the near future.**
- **Have the patient list benefits he or she hopes to obtain from physical activity.**
- **Have the patient choose a preferred and appropriate activity.**
- **Praise the patient's intentions.**
- **Have the patient identify social supporters.**
- **Have the patient identify barriers to activity.**
- **Have the patient rate his or her confidence in being able to do regular physical activity.**
- **Follow up on physical activity at future appointments.**

Action

People in action, the desirable stage, are doing something. They may be exercising at less than the recommended level or they may be maintaining an adequate routine of physical activity. People in action comprise 40% of the general population.

Goal: **Support the patient in continuing his or her activity program.**

How?

- **Reward the patient with praise.**
- **Review the patient's current activity program.**
- **Have the patient identify social supporters.**
- **Have the patient identify barriers to activity (relapse prevention).**
- **Help develop solutions to barriers.**
- **Follow up on his or her physical activity during future appointments.**

Source: "Walk! Texas Health Providers' Guide for Physical Activity," produced by The University of Texas at Austin for the Texas Department of Health Diabetes Program/Diabetes Council. For a copy of this guide or a community start-up kit, call Nancy Stancic, MPH, program specialist with the Texas Department of Health Diabetes Program/Diabetes Council, at (512) 458-7490.

Patients don't want to be told what to do, but they do want to know that their physicians care through their counseling. Dr Lewis teaches his students that "patients don't care that you know until they know that you care." And if an unhealthy behavior is not addressed, a patient may leave thinking, "Well, it must not have been an important enough issue," Dr Huang says.

The strong patient-physician relationships built through this type of counseling may be threatened in a managed care environment that requires patients to switch physicians often, Dr Philips says. "Your physician this year may not be your physician next year, so that's why every physician must counsel every patient," Dr Philips said. "We don't know if these people will be cared for in the future, so we have to ensure that they're cared for properly now."

Solutions through systems

Physicians can get help to counsel every patient on every visit. Once physicians realize the power of their influence and develop the proper communication skills, time becomes the main drawback in health risk behavior counseling. "The literature says that a 3- to 5-minute integration of the message into the visit is very effective," Dr Philips said. But 3 to 5 minutes seems like a lot of time in a 10- to 15-minute patient visit.

For this reason, the experts say the best way to provide

TMA Advantage:
Physician Oncology Education Program's tips for smoking cessation

Ask

- Take a smoking history and chart it for every patient over age 10. Smokers expect the doctor to ask, and most want help. Most smokers started young. Nicotine addiction is real, and most smokers are addicted!
- Assess readiness to change.
- Encourage and inform. Most smokers try to quit many times before they succeed, and each time they learn something that helps. Encouragement by a physician is motivating. Information is most useful if it fits with the smoker's readiness to change.

Advise

- Ask smokers to quit.
- Personalize the danger of smoking by explaining the patient's health risk using physical exam findings or lab test results.
- Promote the belief that quitting is possible and beneficial.
- Recommend nicotine replacement therapy if needed.
- Tailor advice to the smoker's readiness to change. Determine readiness by asking the following:
  - Have you considered quitting?
  - What experience have you had in trying to quit?
  - What do you plan to do to improve your chances of success when you try to quit?
  - What can I do to help?

Assist

- Help the smoker set a date for quitting. (The Physician Oncology Education Program offers the "Rx for Quitting" form as a written reminder for patients.)
- Provide anticipatory guidance, and counsel potential problems, such as weight gain, high-risk situations and people, and stress. Match coping skills with triggers.
- Provide in-office smoking cessation materials and identify helpful staff and community resources that are accessible to smokers.
- Provide prescriptions for indicated pharmacological aides to reduce nicotine cravings.
- Show concern. Smokers, like other patients, appreciate a good listener. Empathetic, trusting relationships that promote self-esteem have been shown to be most effective in breaking addictions. Often, the decision to quit smoking is accompanied by a heightened concern about health.
- Encourage exercise as it helps counteract weight gain and nicotine withdrawal.

Arrange

- Follow up with smokers trying to quit to reinforce their efforts, to identify problems and potential solutions, and to encourage sustained efforts to quit.
- Set an example. Establish a smoke-free office, provide in-office publications about smoking risks and the benefits of cessation, and avoid skepticism.
- Refer smokers who have special needs or who want intensive programs.
- Serve as an advocate for smoke-free communities and schools.

Source: "A for Effort: The Doctor's Role," 2nd ed, 1998. Produced by Texas Medical Association's Physician Oncology Education Program and funded by the Texas Cancer Council. For a copy of this brochure, call (800) 880-1300, ext 1672, or (512) 370-1672; or e-mail poep@texmed.org.

Texas Department of Health helps physicians put prevention into practice

In 1994, the Texas Department of Health (TDH) made improving the delivery of preventive services a priority and established support systems throughout the state to encourage the implementation of Put Prevention into Practice (PPIP), an initiative developed by the US Department of Health and Human Services' Office of Disease Prevention and Health Promotion. Since then, TDH has helped practices develop systems for health risk assessment and follow-up counseling and screening for identified risks. Officials from TDH and The University of Texas System also have evaluated clinicians' documentation of assessment, counseling, and screening for risks such as tobacco use, alcohol/drug abuse, and excess weight. (See "Chart Documentation of Clinical Preventive Services at 9 Texas Clinics," pp 56–62.)

To learn more, attend the TDH PPIP conference, "Clinical Strategies for Systems Change," Monday and Tuesday, August 30–31, at the Red Lion Hotel in Austin. For more information on the conference, which will cover the tools needed to implement comprehensive, high-quality clinical prevention services in a variety of primary care settings, call Linda Jones, MSPH, program specialist for TDH's Adult Health Program, at (512) 458-7534; or e-mail linda.jones@tdh.state.tx.us. To arrange a free clinical preventive services consultation for your office or clinic, contact the specialist in your region or the nurse consultants in TDH's central office:

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preventive counseling is through a system approach that emphasizes teamwork and prioritizes preventive issues. TDH's Adult Health Program promotes system changes to addressing patient behavior through PPIP, Dr Huang says.

"The PPIP initiative is a comprehensive system that addresses all the preventive services recommended by major authorities — substance abuse counseling, injury prevention, mammographies, cholesterol checks, and others — so health care professionals don't miss the opportunity to address these types of behavior when patients come in for acute situations," Dr Huang said. "We recognize, given the time constraints, that we need to prioritize these services within the system so that the physician doesn't take an all-or-nothing approach to preventive care."

PPIP clinical prevention specialists are stationed throughout the state to give office and clinic staffs free assistance in setting up PPIP systems. (See "Texas Department of Health Helps Physicians Put Prevention Into Practice," opposite page.) "We want the physician to really look at using the team of people available so the physician can make the most of his or her time," Ms Mathison said. "The details can come from a nurse, and, in some cases, medical assistants and receptionists can reinforce preventive messages. Posters in the waiting and exam rooms also can reinforce messages."

Though PPIP requires some adjustment, it helps physicians meet accreditation requirements of the National Committee for Quality Assurance, the Joint Commission on Accreditation of Healthcare Organizations, and health maintenance organizations, Ms Mathison says.

The systems approach also includes identifying programs to which physicians can refer patients, such as Walk! Texas, a TDH public health effort designed to encourage physical activity. And systems make good use of preventive resources used by both physicians and patients, such as Texas Medical Association's Physician Oncology Education Program and TMA's new WATCH Project. (See "Watch Out for WATCH," p 36.)

Physicians should remember that even modest changes make major differences when changing unhealthy patient behaviors. "If every doctor were to help 10% of his smoking patients quit, that would be huge!" Dr Gottlieb said. "But they've accomplished something even if they've gotten these patients to seriously consider quitting smoking. They've planted a seed."

In his 26 years of teaching, Dr Philips says he's encountered thousands of physicians-in-training, and they all want to help people have healthy lives. With the right attitude and training, physicians can become proficient in health risk counseling, Dr Philips says. "To all physicians, we owe encouragement and the continued expectation that our doctors continue to be our best sources for information and our greatest allies for changing our behavior." ★

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2. Feldman MK. Shape up! Physicians prod patients to give up bad habits. *Minn Med*. 1993;76:14–20.

Prevention's presence on the Internet

Putting prevention into practice

The Agency for Health Care Policy and Research's Put Prevention into Practice (PPIP) program is a national campaign to improve the delivery of clinical preventive services. PPIP's Web site at www.ahcpr.gov/ppip offers materials designed for physicians, nurses, nurse practitioners, physician assistants, patients, and medical office staffs.

Some preventive guidance

From the site at odphp.oash.dhhs.gov/pubs/guidecps, physicians can download the latest version of the *Guide to Clinical Preventive Services*. The US Preventive Services Task Force, an independent panel first convened in 1984 as an initiative of the US Public Health Service, issued the first revision of its widely used 1989 guide to effective disease prevention and health promotion, based on a careful review of scientific evidence. Many of the recommended changes in the 1995 *Guide to Clinical Preventive Services, 2nd Edition*, reflect new evidence about important health benefits of selected preventive services.

The CDC recipe for good health

An Ounce of Prevention . . . What Are the Returns? a Centers for Disease Control and Prevention (CDC) report that can be downloaded at www.cdc.gov/epo/prevent.htm, outlines 19 prevention strategies and demonstrates how spending money to prevent disease and injury and promote healthy lifestyles makes good economic sense. CDC sites at www.cdc.gov/nccdphp and www.cdc.gov/ncipc/ncipchm.htm discuss chronic disease and injury prevention, respectively.

Healthy People 2000 and 2010

Go to web.health.gov/healthypeople to find information on Healthy People 2000 and Healthy People 2010. The Healthy People national prevention agenda identifies the most significant preventable threats to health and focuses public and private sector efforts to address those threats.

POEP prevention

Texas Medical Association's Physician Oncology Education Program (POEP), located at www.poep.org, helps physicians turn their offices into cancer prevention and detection centers. The site includes continuing medical education opportunities, genetic and pediatric cancer information, and a tobacco resource center.

Strength in numbers

Organized medicine slows Aetna steamroller

Artman

You could practically hear spines shuddering when the behemoth announced it would double its size. Aetna was already notorious for its abhorrent physician contracts and abysmal "slow pay, no pay" reputation. Its $1 billion purchase of Prudential Insurance, physicians feared, would give it more of what it already had too much of — power. Unchecked power, soon to become absolute. ➤➤

By Teri Moran, Senior editor

Observers wondered whether federal regulators would reflexively rubber-stamp yet another managed care merger. At last count, 275 mergers or acquisitions of managed care companies have occurred in this country since 1994, according to a report from Irving Levin Associates, Inc.

Would anyone look past Wall Street to the deal's effect on patients? Given how it would grant Aetna a disproportionate share of the market in many areas, despairing minds wondered what, if anything, could be done.

As it turns out, plenty.

In a surprising victory, the Texas Medical Association, the American Medical Association, and county medical societies proved a compelling enough case that federal and state regulators told Aetna it couldn't buy Prudential unless it sold its NYLCare business in Houston and Dallas-Fort Worth. Aetna agreed to the terms.

Aetna would have controlled 63% of the health maintenance organization (HMO) market in Houston and 42% in Dallas-Fort Worth. But with the NYLCare divestiture, the Aetna-Prudential plan will have a smaller market share in those cities than Aetna had with NYLCare.

Aetna's buyout of Prudential still will create the country's largest health plan with more than 21 million members nationwide, 18 million of them in a managed care plan.

More firsts for Texas

After 6 months of studying the issue, the US Department of Justice (DOJ) and Texas Attorney General John Cornyn filed a civil antitrust suit against Aetna in June in US District Court in Dallas to block its purchase of Prudential. At the same time, officials proposed a consent decree that would allow the purchase to go forward with the NYLCare divestiture.

The DOJ's decision denotes a powerful new shift in regulators' thinking that could bode well for medicine. It is the first time the DOJ has challenged a health plan merger using a civil antitrust lawsuit. Also, for the first time, the DOJ has based an enforcement action on the threat of a health plan's monopsony power over the purchase of physician services. In a monopsony, there is a single buyer of services. For example, had the Aetna-Prudential merger been unchallenged, physicians would have had no other insurer to whom they could sell their services.

"This settlement demonstrates the department's commitment to preserve competition in all sectors of the health care industry," Joel I. Klein, assistant US attorney general in charge of the antitrust division, said in a statement.

Mr Klein said the NYLCare divestitures will not only preserve competition and protect consumers from higher prices, but also will "deny Aetna the ability to unduly depress physician reimbursement rates and thereby impair the quantity and quality of physician services provided to patients."

Opponents of the merger had 60 days from June 21 to file objections. Several other states, including Florida, Kentucky, Georgia, and New Jersey, face similar anticompetitive situations.

How it was done

It started out as a whispered rumor in June at AMA's annual meeting in Chicago, where physicians were busy debating hot topics such as whether to approve physician unions.

Then, word started to spread that the DOJ had reached its highly anticipated decision about the Aetna-Prudential merger. Excited staffers started placing phone calls, and soon the announcement was released over the news wires.

"This settlement protects the consumer by preserving competition," said Texas Attorney General Cornyn in a press release. "Patients will benefit both from the lower health plan prices that competition ensures and from the preservation of quality health care by maintaining competitive physician reimbursement."

It was providential that most of the key players who had worked against the merger were together under one roof in Chicago when the announcement came, and demand for copies of the statement heated up the pressroom's copy machine. TMA and AMA officers and staff, as well as those of the Harris, Dallas, and Tarrant county medical societies, passed the announcement around. The DOJ had asked the county societies and TMA for input about the proposed sale early this year, and everyone had mobilized immediately to provide it, with support from AMA's Private Sector Advocacy team.

"Texas can say to the other states, 'Here's how we did it,' and they in turn can embark on the necessary contacts and data drives so it can be done again and again."

"This is more than a huge win for Texas because it's never just a state story," said Nancy W. Dickey, MD, of Bryan, immediate past president of the AMA. "What better time for this to have happened than here with the entire federation together. Texas can say to the other states, 'Here's how we did it,' and they in turn can embark on the necessary contacts and data drives so it can be done again and again."

Texas' organized medicine representatives gave the DOJ detailed information about problems physicians have had with Aetna. TMA staff created financial models showing the negative financial effect the merger would have on a typical physician's practice. And physician surveys at both county and state levels showed Aetna as having one of the worst records in terms of payment hassles.

But it was the company's own contracts that many observers believe sealed its fate. "The DOJ didn't look just at market numbers and survey numbers and how the business end of physicians' practices would be affected," said Donald P. Wilcox, JD, TMA's general counsel. "They also looked at Aetna's contracts, which made those figures even more alarming."

Aetna's "all products" or "tied products" clauses require physicians to agree to participate in every Aetna

health plan if they want to see patients who are in any Aetna plan. Such clauses give physicians little or no ability to negotiate contract provisions. Physicians must agree in advance to whatever changes Aetna decides to make in the contracts down the road.

Aetna gives itself contractual authority to overrule physicians' determinations of what is medically necessary for their patients and to define medical necessity as "the least costly alternatives."

"Those kinds of clauses illustrated the power Aetna already had," Mr Wilcox said. "Added to the merger equation, they made our case all the more compelling."

As the largest health plan in the state, Aetna-Prudential will have about 2.5 million members in Texas, including 1 million HMO enrollees.

"Aetna's anticompetitive business practices over the past several years have led Texas physicians and their patients to complain vociferously about their treatment," said John P. Howe III, MD, TMA immediate past president.

Health plan musical chairs

"Although we do not agree with the Justice Department's concerns about the effect of the acquisition, a divestiture was the most expeditious way to bring closure to the comprehensive DOJ review process," said Richard L. Huber, Aetna's chair and chief executive officer.

Some 427,000 NYLCare members in Houston and Dallas-Fort Worth will be affected by the deal. "Anytime this happens there's going to be tremendous dislocation for patients and their physicians," said Paul B. Handel, MD, chair of TMA's Council on Socioeconomics.

NYLCare had been losing money when Aetna bought it less than a year ago, and Prudential's health care business in Texas has been bleeding copiously since 1996.

1998 market figures for HMOs in Dallas-Fort Worth and Houston

HMO	Current Enrollment No.	(%)	Proposed Enrollment No.	(%)	Divested Enrollment No.	(%)
DALLAS-FORT WORTH						
Aetna/NYLCare	318,751	(25)	—		—	
Aetna/Prudential/NYLCare	—		489,835	(39)	—	
Aetna/Prudential	—		—		285,393	(22)
NYLCare	—		—		204,442	(16)
Harris Methodist	307,842	(24)	307,842	(24)	307,842	(24)
Prudential	171,084	(13)	—		—	
Texas Health Choice	110,373	(9)	110,373	(9)	110,373	(9)
United	108,530	(9)	108,530	(9)	108,530	(9)
PacifiCare	60,453	(5)	60,453	(5)	60,453	(5)
Humana/PCA	60,032	(5)	60,032	(5)	60,032	(5)
CIGNA	47,296	(4)	47,296	(4)	47,296	(4)
Rio Grande	35,054	(3)	35,054	(3)	35,054	(3)
Other	51,325	(4)	51,325	(4)	51,325	(4)
HOUSTON						
Aetna/NYLCare	446,785	(36)	—		—	
Aetna/Prudential/NYLCare	—		629,498	(50)	—	
Prudential	182,713	(15)	—		—	
Aetna/Prudential	—		—		300,816	(24)
NYLCare	—		—		328,682	(26)
United	91,019	(7)	91,019	(7)	91,019	(7)
Memorial	82,316	(7)	82,316	(7)	82,316	(7)
Rio Grande	62,351	(5)	62,351	(5)	62,351	(5)
Humana/PCA	59,210	(5)	59,210	(5)	59,210	(5)
PacifiCare	52,032	(4)	52,032	(4)	52,032	(4)
Other	279,099	(22)	279,099	(22)	279,099	(22)

Source: Texas Department of Insurance

Physicians look warily to the future when a health plan with Aetna's reputation buys a money-loser like Prudential. What might Aetna be willing to do to turn Prudential into a money-making operation?

"We'll continue to monitor the merger environment on behalf of patients," Dr Handel said. "As the market continues to shift, we'll do all we can to make sure patients have choices in health care. Patients must be able to vote with their feet and walk away from the worst players."

Billions of dollars have changed hands in recent mergers and acquisitions. For example, Aetna merged with US HealthCare in 1997 in an $8.9 billion transaction. Then, Aetna bought NYLCare for $1.05 billion in 1998. It plans to spend $1 billion to buy Prudential.

How much of that money ever goes back into providing services to patients? Probably very little, Dr Dickey suggests. "Most of those dollars typically go to pay off debt and for golden parachutes for executives. It doesn't go back into patient care or capital reinvestment."

While the combined decision of Attorney General Cornyn and the Justice Department is a big win for patients, Dr Dickey believes it's also a huge red flag to America, because it takes a substantial monopsony to get something other than a business-as-usual response from the DOJ. "This shows America how serious this problem has gotten. It's further indication that we need to reform the system."

According to Mr Wilcox, the decision also shows that the system can work. "It shows that there's a chance the government will look at the facts and come to a good decision."

As for patients, Dr Howe added that Mr Huber recently referred to Prudential's member base in Texas as the "filet mignon" of this giant acquisition. "This decision shows that even a huge corporation like Aetna can't treat our patients like just a piece of meat." ★

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Getting blood from turnips

TMA takes aim at "slow pay, no pay" insurers

The saga plays out daily, thousands of times across the country. Every unwitting player knows the story bears all the markings of comedy, something along the lines of Abbott and Costello's classic "Who's on First?" skit: Doctor sees patient; doctor treats patient; doctor sends bill; runaround commences. Months, sometimes years go by, and still the payer, for myriad reasons, withholds the check. Sometimes, the payer plays dumb with questions about a claim like, "Now, who's on second again?" and sometimes the payer just says no, sticking to guidelines that make no sense in the real world. ➤➤

By Teri Moran, Senior editor

What gives?

No longer just an annoying cash flow problem, "slow pay, no pay" has reached epic, tragicomedy proportions. Getting a check on time and in the correct amount from a payer has become the exception rather than the rule. Often, physicians can only guess whether they'll ever get paid.

With unseemly audacity and arrogance, some obstinate companies pretend nothing is wrong, despite passage of a prompt payment law by the Texas Legislature in 1997, largely through the efforts of the Texas Medical Association, which requires claims to be paid within 45 days. But those days may be short lived because the 1999 Texas Legislature passed a new, tougher prompt payment law. Included in the new law is a provision that insurers could be fined $1,000 a day for not paying "clean claims" within 45 days.

One less way out

A slow-pay tactic many payers often employ is to ask physicians for more attachments and more documentation to justify their claims. It's an ongoing bone of contention between carriers and physicians, who often see it purely as a stalling tactic.

The 1997 law that set prompt payment standards for managed care plans requires payment within 45 days of "receiving all necessary documentation for processing the claim."

That definition leaves enough space for the proverbial truck to drive through, and health plans could ask for the whole chart if they want to.

TMA's Corporate Advisory Committee formed a workgroup to develop a "clean claim" definition on which everyone can agree. Because there could be a different definition for every player in the market, the committee's challenge was to create one that had sufficient specificity so that physicians could at some point say, "This claim is clean. Now you can pay it."

"It's much harder to do than it sounds," said TMA President Alan C. Baum, MD, of Houston. "Still, the workgroup kept at it because of its importance to physicians." After workgroup members, including representatives of the Texas Hospital Association, the Texas Association of Health Plans, and the Texas Group Managers Association approved the recommendations (see "This is a Clean Claim," p 49), they sent them to the Texas Department of Insurance (TDI).

In January, TDI said the definition and guidelines looked good, and at press time, the agency was planning to publish proposed rules. TDI will publish the proposed rules, wait for public comment, revise them if necessary, and then adopt them, in a process that will take several months.

Meanwhile, State Rep Kyle Janek, MD, (R-Houston), spurred by complaints from fellow Houston-area physicians, introduced a bill in the 1999 session of the legislature that requires insurers to pay physicians within 45 days of receiving a clean claim, as defined by the TDI rules. Governor George W. Bush signed the bill, which will take effect September 1.

Under the measure, which was worked out with support of the Texas Association of Health Plans, an insurer is required to pay claims within 45 days or say why the claim is being denied. If a claim is partially disputed by a health plan, the plan is required to pay the portion not in dispute.

After the 45-day deadline, health plans can be fined $1,000 per day for each day a claim is not paid. And, physicians will have standing to file complaints with the commissioner of insurance regarding unpaid claims.

"We're making this issue one of our top priorities," Dr Baum says, "because it gives the prompt payment law more teeth and removes a prominent alibi for delayed payments."

TMA has long worked to help physicians with reimbursement problems, even when it often has meant taking on the insurance industry one doctor and one claim at a time. Armed with information from its Hassle Factor Log program, the TMA Health Care Financing Department staff act as ombudsmen, regularly going straight to managed care companies, demanding payment on behalf of physicians. The Hassle Factor Log program facilitates trend analysis and identifies which plans have the worst payment records. (See "Hassle Factor Log Program Status Report, January 1, 1998–May 25, 1999," p 48.) To access the Hassle Factor Log, click on "Business of Medicine" and then "Payment Advocacy" on TMA's Web site at www.texmed.org. The number of Hassle Factor Log complaints received by TMA for the first 5 months of 1999 exceeded the total number received in 1998.

> "We're making this issue one of our top priorities because it gives the prompt payment law more teeth and removes a prominent alibi for delayed payments."

One doctor's story

Lewisville general surgeon Bryan J. Borgfeld, MD, was on call one Saturday in the summer of 1997 at Columbia Medical Center when he was consulted on the case of a 49-year-old woman who had been admitted for 23-hour observation for chest pains. Her workup showed she was a walking stroke or cardiac arrest time bomb, and Dr Borgfeld implanted a permanent pacemaker the next morning. The surgery went well.

Dr Borgfeld didn't request a precertification authorization number from the patient's health maintenance organization (HMO) because he assumed it had already been done. He based that assumption on several things. First, he thought the hospital already had categorized her as an inpatient. He also assumed he needn't ask for one because he had been a consult for her attending physician and because some kind of precertification number was in her chart.

Naturally, without that number, the HMO *couldn't* pay, and Dr Borgfeld embarked on a phone-calling, letter-writing appeal, logging in dozens of phone calls and at least nine letters that were ignored.

He had performed a lifesaving emergency operation in good faith for the patient of an HMO with which he had a contract to provide services. And, he

expected to be paid for it. "His is a classic example of the hundreds of cases like this that happen every day," said Houston urologist Paul Handel, MD, chair of TMA's Council on Socioeconomics. "It's mind boggling the kind of irrational reasoning some plans use to justify holding back payment, and worse yet, the length of time it can take to resolve the problem."

Never-ending battle

Every couple of months, Teresa Devine, director of TMA's Health Care Financing Department, prepares several 4-inch-thick notebooks full of individual physicians' cases. She, her staff, and Dr Handel meet with the medical directors of various payers, including managed care plans and the state's Medicaid and Medicare carriers. There, they tactfully lay out concrete evidence of payment foul-ups.

A year and a half after Dr Borgfeld implanted that pacemaker and still hadn't been paid, he submitted to TMA a Hassle Factor Log describing his problem. His case was one Ms Devine and Dr Handel took to a carrier meeting. It wasn't resolved immediately, but finally, in April 1999, the HMO paid. Did

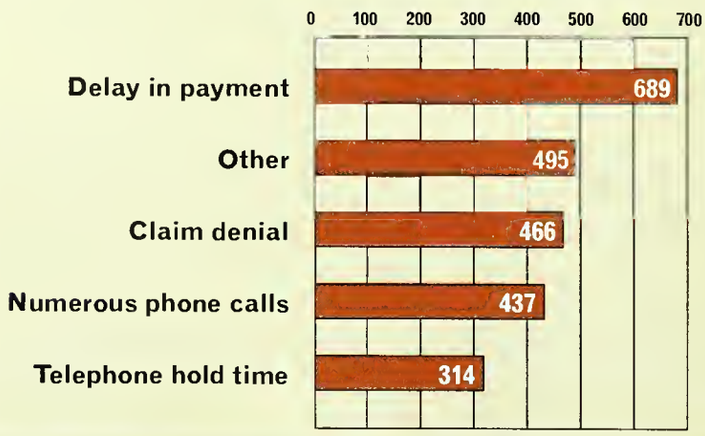
Hassle Factor Log program status report, January 1, 1998–May 25, 1999

Number of hassles reported, by carrier

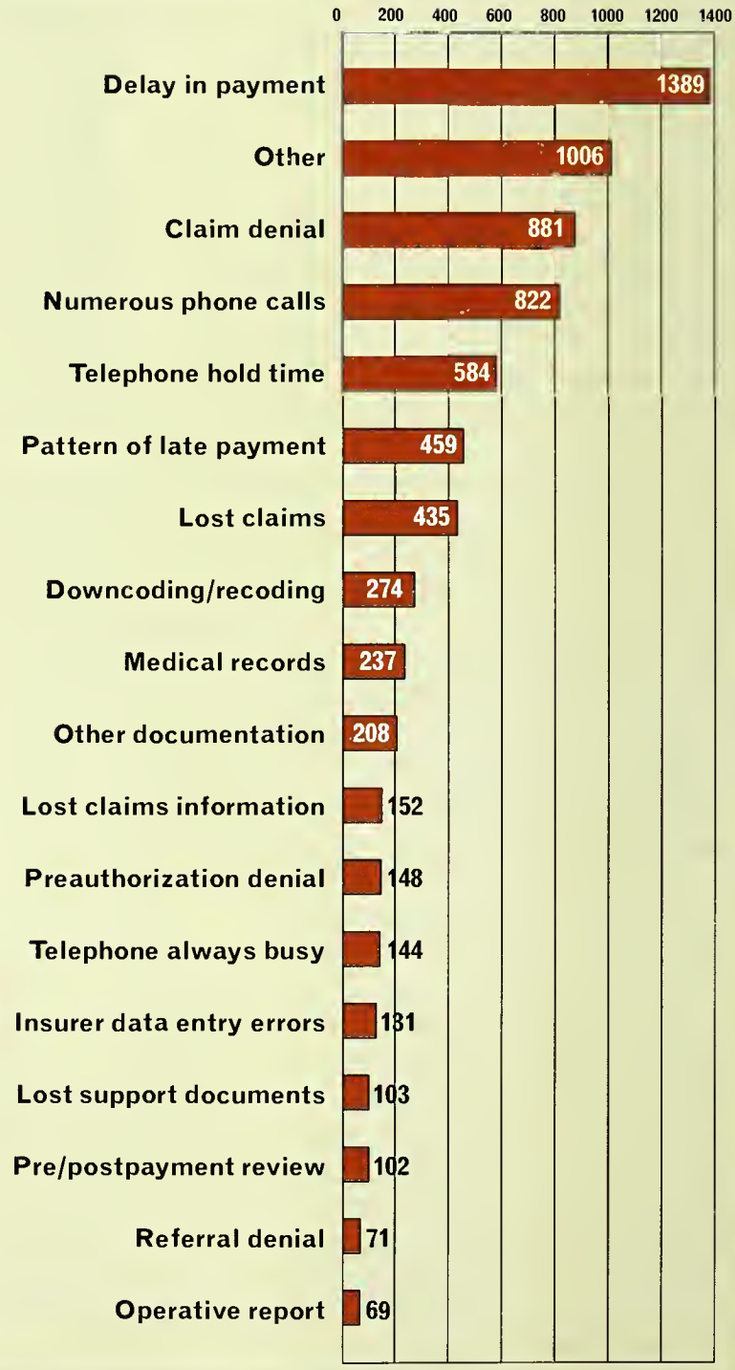
This report represents all provider complaints, not just those regarding payments. The carrier category identifies the name of the parent company and does not differentiate the type of plan about which a physician submitted a complaint. The numbers include only those logs that specified a carrier name.

	Hassles			
	1999		1998	
Carrier	No.	(%)	No.	(%)
Prudential	294	(10)	235	(10)
Aetna	228	(8)	167	(7)
United Healthcare	227	(8)	144	(6)
Blue Cross Blue Shield	171	(6)	117	(5)
CIGNA	141	(5)	78	(3)
NYLCare	124	(4)	78	(3)
Humana Health Plan, Inc	70	(2)	32	(1)
Unicare	55	(2)	45	(2)
NHIC	51	(2)	45	(2)
Other program types	1,637	(55)	1,302	(58)
Total	2,998		2,243	

Top five reported hassles for managed care



Types of hassles reported



it pay in full? "Oh, heck no. Not even the normal pittance," Dr Borgfeld's office manager told *Texas Medicine*.

"We've been able to secure payment in many instances where it's likely the physician acting alone would never have succeeded," Ms Devine said. "In most cases, the doctor has spent futile months working through the plan's appeals process, getting nowhere, trying to get paid for legitimate claims."

We're not talking nickels and dimes here either, adds Dr Handel. "Some physicians are owed thousands and thousands of dollars — so much money, in fact, that I personally know physicians whose practices hang by a financial thread because they just aren't getting paid."

The meetings, which TMA initiated a decade ago, are quite cordial, even though the same problems are taken to the same carriers time and again. And as effective as the carrier meetings have been and continue to be, the word "stonewall" comes to mind when TMA representatives describe their advocacy efforts.

But while such apparent stonewalling seems suspiciously intentional, it's worthy to note that while the tumult in today's health care industry swirls like a hurricane, managed care plans spin in its eye. In the beginning, things were much different. When TMA first sat down with managed care plans in the early 1990s to present physicians' hassles, the plans arrived eagerly, anxious to, well, show off.

"They believed their product was superior and they were anxious to boast its merits," said Louis J. Goodman, PhD, TMA's executive vice president. "They felt they had found a better mousetrap." As the then-director of TMA's Division of Medical Economics, Dr Goodman initiated the carrier meetings in 1988, first with Medicare, then with Medicaid.

When TMA first showed HMO medical directors the proof of physicians' numerous hassles, they were flabbergasted, Dr Goodman says. "They had no idea that there were problems, and at first, they resisted. But when we sent them all the documentation and they read it, they admitted there were issues that needed to be addressed."

This is a clean claim

Texas Medical Association's Corporate Advisory Committee in 1998 took on the task of developing a "clean claim" definition to address delays in claim payments from health care payers.

The committee formed a workgroup that included members of the Texas Hospital Association (THA), the Texas Association of Health Plans (TAHP), and the Texas Medical Group Management Association (TMGMA).

The workgroup recommended using Medicare's clean claim standards because most physicians, hospitals, and other health care professionals already are equipped to bill for Medicare. The workgroup sent the following recommendations to the Texas Department of Insurance (TDI), which said it plans to use them as the basis for its proposed rules.

Recommendations

1. **The clean claim elements of Medicare should be used as the baseline for Texas' definition of a clean claim. A clean claim is a TDI-approved or identified claim format that contains all data fields required by the health plan for final adjudication. For payment purposes, the required data elements must be complete, legible, and accurate. Clean claim elements are those required by Medicare to process and adjudicate a claim. A clean claim also may include claim requirements a health plan has published.**
2. **If a health plan obligates physicians and other health care professionals to complete more claim items than the core required set, it must disclose the additional "optional" or "conditional" clean claim elements within its individual contracts and manuals.**
3. **A health plan may amend its clean claim requirements, but with 60 days' notice to all participating providers. For a health plan that contracts with limited provider networks, disclosure to the network is sufficient.**
4. **A health plan must identify ahead of time the services and procedures for which it routinely requires attachments.**
5. **A health plan must disclose in its manuals where claims should be sent for processing, including the address and a phone number to call for questions or concerns. The plan also must say whether it has delegated its claims payment functions to any other intermediary or whether it maintains separate processing centers for "carve-out services" such as behavioral health, and it must provide the address(es) where claims must be sent.**
6. **A health plan may not deny a claim when it changes its claims processing address without giving sufficient notice. An example is when a health care professional submits a claim to a health plan only to discover the address is no longer correct. Then, when the provider resubmits the claim, it is denied for having been filed past the filing deadline.**

Other issues for further deliberation include:

- **Notification for "defective" claims;**
- **Partial payments;**
- **Standardized explanation of benefits and remittance advice;**
- **Notification on patient ID card of where claims should be sent;**
- **Coordination of benefits payment; and**
- **Requirements to submit hospital records to reimburse physicians for inpatient care.**

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The HMO medical directors' cooperative spirit made things look as though they would work well at first, according to Dr Goodman, the way they had been working with Medicare and Medicaid. But over time, things changed. The industry's explosive growth saw mergers, acquisitions, personnel changes, and fewer physician outreach programs. Soon, clerks, instead of medical professionals, became the point-persons at HMOs.

"None of the medical directors are in place now who were in place when we started these meetings," Dr Goodman said. "What began as something with considerable potential has evolved into something much more difficult."

Even cooperative medical directors of HMOs who want to help sometimes simply can't, Dr Goodman says. "Unfortunately, they don't have enough clout in the management structure, and that's where the problem is."

Hitting from all angles

The Hassle Factor Logs may not seem like much in the grand scheme of things, but they ultimately help shape TMA's goals and policies, providing necessary, specific details of where the association should flex its muscles. It's hard for an HMO to hide or make excuses when its medical director can see firsthand, and in black and white, the concrete details of the payment problems physicians experience.

"We're very successful at the one-doctor, one-claim level," Ms Devine said. "But, of course, less so at the corporate level where global issues are decided," which is precisely where many payment problems could be made to disappear, if plans would revise their policies.

Dr Handel believes many plans have begun to appreciate that working with Texas physicians through TMA has its benefits. "Through our joint efforts, HMOs can see where they need to put more education and resources." Still, the kind of relationship-building normally associated with similar successful efforts has been difficult, if not impossible, to obtain, Dr Handel says, because the medical directors change so frequently.

> "They had no idea that there were problems, and at first, they resisted. But when we sent them all the documentation and they read it, they admitted there were issues that needed to be addressed."

As TMA's database of information from physicians grows through its Hassle Factor Log program, other TMA staff work other angles. One-on-one help is usually just a phone call away when TMA members have payment problems, and the association has one expert, Pat Coffey, who spends much of his time on the road, training physicians and physician groups in mini-consults. Like private investigators, Ms Devine and her staff, as well as others in the TMA Division of Medical Economics, keep tabs on plans' performance and their fingers in numerous pies. They bring problems to the attention of TDI and maintain high visibility at other regulatory agencies, such as the Health Care Financing Administration.

Such strategies work. A short list of successes includes instances where TMA has influenced carriers to not bundle claims, to change their physician review processes from arbitrary audits to focused medical reviews, and to accept coding modifiers they had previously denied.

New state laws and regulations regarding claims payment will not solve all of medicine's concerns about managed care, but they will give TMA more clout in dealing with insurance companies when it comes to critical issues such as physician reimbursement. ★

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The big payback

Texas physicians challenge Blue Cross and Blue Shield's practices

Regan Dunnick

"No one believes Blue Cross and Blue Shield in any way has warm and toasty feelings toward Texas physicians." So says Richard Toranto, MD, of Dallas, and he should know. His lawsuit against the insurer is being considered for class action status, joining another recently settled class action case against Blue Cross and Blue Shield of Texas (BCBS). In both cases, BCBS was sued over its procedures for reimbursing physicians. ➤➤

By Monica Maldonado, Associate editor

Toranto v Blue Cross and Blue Shield of Texas, Inc

When Cheri Webb received a check from BCBS to pay Dr Toranto, a plastic surgeon who had operated on her in 1993, she used the money to make a down payment on a house. She pleaded ignorance and bad math skills to Dr Toranto, saying she thought BCBS had already reimbursed him for the procedure because she had assigned her benefits to him and she thought that the insurance check from BCBS was for an overpayment.

As a state employee, Ms Webb's insurer was the Employees Retirement System of Texas' (ERS's) health benefits plan, which selected BCBS as its administrator. Though Ms Webb had assigned her benefits to Dr Toranto, ERS had an anti-assignment clause, which prevented payment to anyone but her. When Dr Toranto filed a claim, BCBS refused to pay, calling upon the ERS clause. Dr Toranto sued BCBS, alleging the plan's anti-assignment clause was invalid under the Texas Insurance Code.

In district court, BCBS argued that because it acted as ERS's administrator, it wasn't an insurer and therefore was not held to the insurance code's anti-assignment prohibition. The trial court ruled in favor of BCBS, and the decision was upheld on appeal.

Dr Toranto chalks the initial losses up to "less than competent attorneys and less than knowledgeable judges," but says he knows he was right. "Most people let it go after they lose in trial court, but the further I went through the courts and the more I learned about the Texas Insurance Code, the more I thought I was right."

At the time, Dr Toranto was working toward a law degree at the Southern Methodist University School of Law. In researching the case, he called upon one of his professors, William Dorsaneo, JD, who, along with Jeffrey Kyle, JD, assisted him in writing an appeal petition to the Texas Supreme Court. The court's decision was clear: it ruled that BCBS did have to abide by the rules of the Texas Insurance Code. It reversed the appeals court's judgment and remanded the case to the trial court.

In its opinion, the Supreme Court declared ERS's anti-assignment clause invalid. As it interprets the Texas Insurance Code, the court said, ERS is an insurer subject to the code and "BCBS is an 'insurer' because it is authorized to act as ERS's administering firm . . . and is therefore subject to the anti-assignment prohibition."

In a prepared statement, BCBS said, "As the claims administrator for ERS, BCBS is contractually bound by the terms and conditions of the ERS document. Dr Toranto's patient was promptly paid in the amounts of money due under that plan document."

"Most people let it go after they lose in trial court, but the further I went through the courts and the more I learned about the Texas Insurance Code, the more I thought I was right."

It continued, "While we certainly respect the Texas Supreme Court's decision regarding *Toranto v Blue Cross and Blue Shield of Texas, Inc,* it's important to realize that the clause in question was part of the terms and conditions of the plan document adopted by the trustees of ERS. This was not an insurance policy issued by BCBS. The unfortunate aspect of the court's decision is that it voided a provision of the ERS's plan document, even though ERS was not a party to the suit and was not able to present its position and concerns to the court."

"BCBS's whole argument was that it was just a claims administrator," said Mr Kyle. "But Texas law says that even if it's acting as an agent for another agency, it has the same responsibilities as the agency it's acting for." Dr Toranto says BCBS was fully aware of its obligations under this aspect of the Texas Insurance Code, especially because the insurer had opposed it during its initiation in the 1993 Texas legislative session.

The class action petition has already been filed with the trial court with Dr Toranto as the lead plaintiff. Mr Kyle says they expect the class action to be granted by the end of 2000 and followed by a notice letter to health care professionals who could be eligible to join the lawsuit. The Dallas County court will decide how retroactive the claims could be, how much would be awarded to which claimants, and how much of the attorneys' fees the defendant will pay. Dr Toranto recommends physicians contact attorney Tom Wright, JD, at (713) 752-2322, if they believe they could be part of the class action.

Morris and McCarthy v Blue Cross and Blue Shield of Texas, Inc

Psychiatric partners Brock Morris, MD, and Sean McCarthy, MD, of Waco, suspected that the reimbursement rates from BCBS's ParPlan and FedSelect plan were too low. But when they questioned the insurer about how it calculates its reimbursement rates, BCBS replied that its rates were based on "reasonable charges" based on the "prevailing rates" for their area. "Physicians are all so busy," said Dr Morris. "I just didn't pursue questioning them further at the time."

Dr McCarthy eventually learned of a class action suit against BCBS, which began as a payment dispute filed by a patient. During the discovery portion of that case, attorneys from the law firm Malesovas, Martin & Tekell learned BCBS had a particular way of calculating its reimbursement rates, a peculiarity that struck a nerve with Drs Morris and McCarthy. (The patient's suit was settled recently.) The doctors contacted the attorneys representing the patients and decided that they, too, would sue BCBS for breach of contract to pin down the insurer about its reimbursement rates.

Legal articles in *Texas Medicine* are intended to help physicians understand the law by providing legal information on selected topics. These articles are published with the understanding that TMA is not engaged in providing legal advice. When dealing with specific legal matters, readers should seek assistance from their attorneys.

Depositions from an August 1998 pretrial discovery tell the whole story. At the discovery, Vice President and Medical Director David Sowell, MD, (now retired) admitted that BCBS did not update its reimbursement rates regularly to reflect the prevailing charges as it had said it would in its contracts with physicians. Its reimbursement rates were based solely on calculations from 1991.

In the deposition, Dr Sowell said, "[In 1991] we made the decision that we wished to use the fees that we already had [1990 fees] and stop going through this procedure on a twice annual basis because that did tend to inflate fees and cause some fees to grow much faster than others. . . . So in 1991 it was simply frozen, such that whatever was in place in July 1991 has been the fee since that time." It turned out that as late as April 1997, Texas physicians who had contracted with BCBS's ParPlan were being reimbursed for most procedures at 1990 rates.

BCBS had frozen its reimbursement rates since that date despite having informed physicians and the Texas Department of Insurance that it had been evaluating the rates regularly. The insurer also admitted it had trained its employees not to tell physicians how its reimbursement rates were calculated.

The discovery session also revealed that BCBS's actuaries had determined that medical costs had increased by 11% per year for policyholders since 1991, yet that information was never used to update the reasonable charge database. Attorneys for Drs Morris and McCarthy noted that BCBS has about 30,000 ParPlan contracts with physicians in Texas. In their complaint to the district judge, the plaintiffs' attorneys continued, "BCBS's underpayment scheme . . . has gone undetected not only because of BCBS's ongoing misrepresentations and its ParPlan contractual arrangements with its medical providers, but also because of the fact that the underpayments are spread among so many different claims."

The district court judge went on to grant the physicians' lawsuit class action status. In April 1999, the plaintiffs' attorneys released a notice of the class action, which alerted other physicians involved to the settlement. The settlement with about 22,000 medical professionals and physicians is just more than $5 million, with BCBS paying an additional $5,000 to Drs Morris and McCarthy as class representatives, and attorney fees. The judge's approval of the settlement discharges and extinguishes the claims against BCBS.

"We settled because we could have lost and received nothing, and BCBS settled because it ultimately could have paid more."

David Tekkell, JD, a partner in the law firm representing the physicians, said, "We settled because we could have lost and received nothing, and BCBS settled because it ultimately could have paid more."

Dr Morris said calling BCBS on its practices was "like catching a kid stealing candy, but he doesn't admit it until you pull it out of his hand." BCBS was unable to respond to questions regarding this case at press time.

Attorneys for Dr Morris estimated a suit would have resulted in BCBS having to pay close to $80 million, but at the time, BCBS of Texas was trying to merge with BCBS of Illinois and, as Dr Morris says understatedly, the class action "would have really made them uncomfortable." ★

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Chart documentation of clinical preventive services at 9 Texas clinics

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Documentation of clinical preventive services at 9 Texas family practice residency programs, community health centers, and public health regional clinics was examined. Assessment of 11 risks, counseling on those risks, and timeliness of 8 screening tests and immunizations were abstracted.

Documentation of clinicians' risk assessment focused on tobacco use (56.4%), alcohol/drug abuse (45.8%), and excess weight (21.6%). Counseling was documented most often for nutrition (20.5%), family planning (11.6%), and physical activity (10.3%). Of the sites studied, public health regional clinics had the highest documentation of assessment and counseling. Community health centers were most up-to-date for diabetes and cholesterol screening. Family practice residencies documented the highest rate of counseling for obesity risk.

Clinicians do not document risk assessment, counseling, or up-to-date screening tests and immunizations for most of their adult patients. Texas practitioners may need support or assistance to provide universal access to clinical preventive services.

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INTRODUCTION

The national health objective 21.4 of Healthy People 2000 is "to assure that at least 90 percent of people for whom primary care services are provided directly by publicly funded programs are offered, at a minimum, the screening, counseling, and immunization services recommended by the US Preventive Services Task Force" (1, p 537). These recommended services are referred to as clinical preventive services, and specifically include individualized counseling relating to high risks, age- and/or gender-appropriate screening tests, and age-appropriate immunizations (1). Research on documentation of preventive services has focused traditionally on testing and immunizations (2). Details of chronic disease screening and immunizations are more easily found in chart audits through laboratory slips, consent forms, and documentation of fees charged (3,4).

Many barriers block the provision of clinical preventive services by clinicians. Lack of motivation, lack of training, uncertainty about effectiveness, and lack of reimbursement by payers have all been identified (5,6). Physicians report also a lack of patient interest and barriers in the health care setting itself (7,8). Residency training in hospitals stresses the writing of orders to be carried out by other staff. Diagnosis of problems, rather than collaborative lifestyle counseling, is the focus of most medical training. Patient education, which involves patients in determining their health status, risks, needs, and plans for change, requires a significant change from the manner in which most physicians were taught (9,10).

In this study, we searched patient charts to find evidence of assessment of need for counseling (high risk) as well as documentation of counseling provided. The data presented here were collected before an intervention designed to increase the practice and documentation of such behaviors by clinicians. This baseline inquiry examined also the documentation of screening tests and immunizations. We then examined the data for trends in practice style that may have been affected by the type of clinic.

METHODS

Site types

We examined medical charts of 4 family practice residency programs, 3 community health centers, and 2 public health regional clinics. The residency program and community health center sites received funding, through a competitive process from the Texas Department of Health (TDH), to implement Put Prevention into Practice (PPIP). This research-based system was designed by the Office of Disease Prevention and Health Promotion of the US Department of Health and Human Services to "assist clinicians in the performance of . . . clinical preventive services" (11). The public health regional clinics volunteered to participate without supplemental financial support.

We found differences in clinician resources among site types. The number of residents in family practice residencies ranged from 18 to 72, while the number of doctors at community health centers ranged from 2 to 6, with 1 to 4 physician assistants, nurse practitioners, or part-time physicians. The clinicians at the 2 public health regional clinics consisted of 1 part-time nurse practitioner with 1 full-time registered nurse or 2 full-time registered nurses.

Data collection

The auditing process consisted of collecting data from charts of patients 19 years and older seen during the 6 months before implementation of PPIP (September 1, 1993, through February 27, 1994). Seventy-five medical charts were collected at each of the 9 sites.

The Battelle Adult Chart Review Form (3) was adapted by the TDH Bureau of Disease and Injury Prevention. A protocol and guidelines for the abstracting process were developed by the research team, reviewed by TDH, and approved for use. The adapted review form, protocol, and guidelines were pilot tested and found to be appropriate.

All chart audits were performed by a single registered nurse, trained to select charts and abstract data according to the protocols. By using appointment logs, patient charts were chosen systematically to ensure distribution throughout the times of the day and days of the week, and among providers for each clinic site to cover the 6-month period. Chart audits were completed between August 1994 and March 1995.

Evidence of risk assessment and counseling could be found in progress notes, annual histories, or annual physical forms. For this particular baseline, assessment of risk documented any time within a 1-year period was included. Counseling was audited for 6 months, based on an early draft of the Battelle instrument, and was later changed to 1 year. Documentation of assessment of risk, of counseling within the appropriate periods, and of timeliness of each screening test and immunization were coded as dichotomous dependent variables. Differences among types of sites were determined through chi square analyses. A Bonferroni correction was used to control for inflation of alpha level, and $P < .05$ (Bonferroni .001) was set as the significance level.

Dates of the most recent screening tests and immunizations were obtained. We assumed that all patients should receive a minimum set/number of the screening tests and immunizations appropriate for a nonsymptomatic person. Timeliness of these tests and immunizations was computed according to TDH Adult Health Program standards (12), presented in Table 1.

Table 1. Standards for age- and gender-appropriate screening tests and immunizations.

Screening test or immunization	TDH Standard/Guideline Used for Analyses	Operationalization for Analyses
Pap test	Women annually at onset of sexual activity. If 3 or more satisfactory normal annual exams, may be performed every 1-3 years.	Women aged 21+ years, within last 3 years
Clinical breast examination	Women aged 20–39 years, every 3 years Women aged 40+ years, every year	Women aged 23–40 years, within last 3 years Women aged 41+ years, within last year
Mammogram	Women aged 40–49 years, every 1-2 years Women aged 50+ years, every year	Women aged 42–50 years, within last 2 years Women aged 51+ years, within last year
Tetanus-diphtheria	All adults, every 10 years	Adults aged 26+ years, within last 10 years
Pneumovax	All adults aged 65+ years, 1 time	Recorded ever for patients age 66+ years
Influenza	All adults aged 65+ years, once/year	Adults aged 66+ years, within last year
Diabetes screen	All adults, every 3 years (or more frequently, at the discretion of the clinician)	Adults aged 21+ years, within last 3 years
Cholesterol screen	All adults aged 20+ years, every 5 years if last screen normal, every year if last result abnormal	Adults age 25+ years, within last 5 years

TDH = Texas Department of Health

This table also depicts the operationalized constructs we used for data abstraction and collection.

RESULTS

Texas clinicians in our sample documented risk for tobacco use most commonly, evidenced in 56.4% of the patient charts during the prior year (Table 2). This was followed by assessment for alcohol/drug abuse (45.8%), excess weight (21.6%), family planning (16.4%), physical activity (15.8%), and nutrition (15.2%). Overall, topics least covered were tuberculosis (3.9%), skin cancer (5.2%), and sexually transmitted disease/human immunodeficiency virus (STD/HIV) risk (6.5%).

The 3 types of sites differed significantly by assessment focus for 7 of the 11 topics examined. Public health regional clinics assessed for risk of skin cancer (19.5%), tuberculosis (10.7%), and poor nutrition (26.2%) at a higher rate than did the residencies and community health centers. However, these clinics documented a lower rate of assessment for obesity. Community health centers documented assessment of alcohol or drug risks for a higher percentage of patients (60.2%) than did the other 2 types of clinics. Family practice residencies documented assessment of safety-

Table 2. Assessment for risk within the last year documented in charts of Texas practitioners from September 1993 to March 1994.

Topic Documented as Assessed	Combined Sample, % (n = 672)	FPR, % (n = 297)	CHC, % (n = 226)	PHRC, % (n = 149)	Chi Square df = 2
Tobacco/smoking	56.4	53.2	61.1	55.7	3.265
Alcohol/drug	45.8	37.4	60.2	40.9	28.728*
Excess weight	21.6	24.9	25.2	9.4	16.795*
Family planning	16.4	12.1	19.5	20.1	7.044
Physical activity	15.8	12.5	15.9	22.1	7.018
Nutrition	15.2	11.8	12.4	26.2	18.016*
Safety	14.7	2.0	26.5	22.1	69.849*
Adult immunizations	13.4	3.4	20.8	22.1	46.264*
STD/HIV	6.5	5.7	5.3	10.1	3.912
Skin cancer	5.2	0	2.7	19.5	80.628*
Tuberculosis	3.9	1.0	3.1	10.7	25.792*

* $P<.05$
FPR = family practice residency programs
CHC = community health centers
PHRC = public health regional clinics
STD/HIV = sexually transmitted disease/human immunodeficiency virus

related (2%) and adult immunization risks (3.4%) at a lower level than did the other 2 types of sites.

Clinicians documented counseling most often for nutrition (20.5%), family planning (11.6%), and physical activity (10.3%) (Table 3). Counseling for risk of tobacco/smoking, alcohol/drug, and STD/HIV issues was recorded for 10.1% of patients for each risk category.

Six significant differences emerged among the 3 site types. Public health regional clinics had the highest rates of documentation of education or counseling for tobacco use/smoking (25.5%), alcohol/drug use (36.2%), family planning (34.2%), nutrition (36.9%), and STD/AIDS (32.2%). Family practice residencies documented the highest rate of counseling for obesity (9.4%).

Examination of charts according to the standards listed in Table 1 revealed that female patients were up-to-date for Pap smears in 73.3% of cases (Table 4). Seventy-one percent of women aged 23 to 40 years had received a clinical breast examination within the last 3 years. Diabetes and cholesterol screens were up-to-date for 61.1% and 57.8%, respectively, of all eligible patients. Less than half of the charts examined within the appropriate age groups contained evidence of timely provision of the remaining 6 tests and immunizations.

Comparison of the 3 types of clinical sites revealed significant differences for 5 of the medical prevention topics. Public health regional clinics were the most up-to-date for Pap smears but below the other sites for timeliness of diabetes screens and cholesterol testing. Family practice residency programs were less likely to document provision of clinical breast examinations for women aged 23 to 40 years and tetanus-diphtheria immunizations every 10 years.

DISCUSSION

The Healthy People 2000 goal of universal access to clinical preventive services is supported solidly by McGinnis and Foege's estimation of the behavioral causes of death in the United States (13). An improvement in the overall health of Americans can be made through assessment and counseling in relationship to the everyday behavioral factors (such as tobacco use, diet and activity patterns, and alcohol use) heading the McGinnis and Foege list (14,15).

National surveys of the attitudes and beliefs of practitioners show that most believe in the value of prevention (16–18). While self-report of the practice of preventive medicine is encouraging (19–21), measurements of actual practice (either through patient interview, chart audit, or a combination of methods) fall below both Year 2000 objectives and survey-espoused practice (22–25).

Texas physicians and physician assistants self-report that the practice of prevention is at a high level (26–29). The only chart audit study of Texas residents revealed low levels of screening tests for both nonsymptomatic and symptomatic patients (30).

Another perspective on the health risks of Texans is revealed by the Behavioral Risk Factor Surveillance System (BRFSS) surveys conducted during the time of this study (1993 and 1994). During 1993, of 2495 randomly selected respondents, 26.1% were overweight (according to self-reported height and weight and based on body mass index), 23.8% indicated they were current smokers, and 25% reported they did not routinely use seat

belts. Sixty percent of women 50 years and older reported that they had had a mammogram and clinical breast examination within the last 2 years, and 86% of women reported being up-to-date for Pap smears (within the last 3 years). Among adults 65 years and older, 56% said they had received an influenza immunization in the last 12 months, and 36.9% had had the recommended pneumovax immunization. Of the 1498 respondents to the 1994 survey, 56.5% admitted to a sedentary lifestyle, and 35.4% reported a current attempt to lose weight. According to the BRFSS respondents themselves, clinical preventive services provided to Texans need to be increased (31).

In a similar fashion, documentation levels from our sample fall short of providing universal access to clinical preventive services. The chart evidence for up-to-date screening tests and immunizations is more encouraging than that pertaining to risk assessment and counseling.

Table 3. Counseling for 11 risk topics within a 6-month interval documented in charts of Texas practitioners from September 1993 to February 1994.

Topic Documented as Counseled	Combined Sample, % (n = 672)	FPR, % (n = 297)	CHC, % (n = 226)	PHRC, % (n = 149)	Chi Square df = 2
Tobacco/smoking	10.1	8.8	1.8	25.5	56.703*
Alcohol/drug	10.1	3.4	1.8	36.2	144.001*
Excess weight	5.2	9.4	2.2	1.3	19.329*
Family planning	11.6	3.7	7.1	34.2	96.911*
Physical activity	10.3	9.4	11.1	10.7	.418
Nutrition	20.5	16.8	14.6	36.9	31.858*
Safety	0	0	0	0	N/A
Adult immunizations	1.9	2.0	3.1	0	4.562
STD/AIDS	10.1	2.7	5.3	32.2	103.735*
Skin cancer	0.4	0	0.4	1.3	4.023
Tuberculosis	0.1	0	0.4	0	1.976

* $P<.05$
FPR = family practice residency programs
CHC = community health centers
PHRC = public health regional clinics
N/A = not applicable
STD/HIV = sexually transmitted disease/human immunodeficiency virus

Assessment and counseling by resident physicians

The rates of assessment and/or counseling for various preventive health topics among resident physicians have been examined through other chart audits (23,32,33). The Texas residents studied had higher rates of assessment for tobacco use (53% vs 32%) and nutrition (11.8% vs 8 %) and had a similar rate of assessment for physical activity (12.5% vs 14%) in comparison with a sample of California family practice residents (23). For counseling, these other studies used a 1-year period, twice the time we used in our study. Nonetheless, we found higher rates of documentation of counseling for tobacco use (8.8% vs 2.5%) and nutrition (16.8% vs 7%). Similar rates for STD risk (2.7% vs 3.5%) and physical activity (9.4% vs 8%) counseling during 6 months among the Texas residents, when compared with the 1-year documentation of those in a family practice residency program in Cleveland (32), indicate consistently higher documentation of counseling for our sample of residents.

We found no chart audit studies examining needs assessment or counseling in community health centers. Public health clinics are also not represented in this type of study.

Screening tests and immunizations

More has been published about the provision of medical preventive services in various clinical settings (18,25,30,34–38). Our combined sample showed more up-to-date documentation of Pap smears (73% vs 4% and 50%) (36,38) and clinical breast examinations for women aged 23 to 40 years (71% vs 19.5% and 69%) (32,35) than the literature. Our combined Texas sample (54.5%) ranked in between an early study of Texas residents (6%) and a Nebraska health maintenance organization (HMO) (92%) for cholesterol testing (30,39). The rates for mammography in our sample (30.2% for women older than 51 years) were lower than those found in samples of private physicians in the Northeast (54%) (35), an urban public health clinic (47%) (40), and a California HMO (75.5%) (18). The overall rate found in our study for annual influenza vaccination of older adults (36.6%) was lower than those documented for HMO members (65% and 54%) (41,18). However, the rate documented by our

Table 4. Timely age- and gender-specific screening tests and immunizations documented in charts of Texas practitioners from September 1993 to February 1994.

Screening Test or Immunization	Combined Sample Charts, %	FPR, %	CHC, %	PHRC, %	Chi Square df = 2
Pap test (women aged 21+ years)	73.3 (n = 483)	62.1 (n = 198)	73.8 (n = 160)	90.4 (n = 125)	31.329*
Clinical breast examination (women aged 23-40 years)	71.0 (n = 245)	48.0 (n = 102)	80.7 (n = 57)	91.9 (n = 86)	46.917*
Clinical breast examination (women aged 41+ years)	41.6 (n = 202)	40.4 (n = 92)	39.1 (n = 89)	57.1 (n = 21)	2.368
Mammogram (women aged 42-50 years)	27.7 (n = 47)	33.3 (n = 21)	29.4 (n = 17)	11.1 (n = 9)	1.596
Mammogram (women aged 51+ years)	30.2 (n = 149)	40.3 (n = 67)	25.4 (n = 71)	0 (n = 11)	8.792
Tetanus-diphtheria (ages 26+ years)	17.2 (n = 540)	6.6 (n = 258)	29.7 (n = 192)	21.1 (n = 90)	42.343*
Pneumovax (ages 66+ years)	19.4 (n = 93)	15.1 (n = 53)	32.3 (n = 31)	0 (n = 9)	6.083
Influenza (age 66+ years)	36.6 (n = 93)	35.8 (n = 53)	48.4 (n = 31)	0 (n = 9)	7.068
Diabetes screen (ages 21+ years)	61.1 (n = 638)	62.4 (n = 287)	75.9 (n = 216)	34.8 (n = 135)	59.429*
Cholesterol (ages 25+ years)	57.8 (n = 557)	60.6 (n = 264)	73.0 (n = 196)	19.6 (n = 97)	77.391*

*$P<.05$
FPR = family practice residency programs
CHC = community health centers
PHRC = public health regional clinics

sample of family practice residents (35.8%) was similar to that found for residents practicing in a Veterans Administration continuity clinic (37.5%) and higher than those documented by Illinois residents (12.5%) (36,38). Our family practice residency rates for pneumonia vaccination were higher (15.1%) than those found by Cowan (zero) (36), Morris (7%) (30), and Kikano (8%) (32) in other residency programs.

Site types

Our findings for women's screening and risk assessment and counseling for family planning at the public health regional clinics were consistent with their strong historical role as providers of family planning services and children's care (42). In Texas, however, these sites had participated previously in the Adult Health Risk Assessment Program, which used a type of health risk profile (43). This experience was likely associated with the high rates of assessment for nutrition and skin cancer, as well as for counseling regarding tobacco, alcohol, nutrition, and STD/AIDS. The lower rates found for mammography and for diabetes and cholesterol testing in these sites are consonant with a lack of referral resources and funding for indigent preventive care. With the current shift to Medicaid managed care for indigent patients in Texas, resources should no longer be a barrier to preventive care for this population (44).

Our findings for community health centers correspond with their role of providing clinical, preventive, and social services to meet community needs. Their consistent use of programmatic grant funding, in combination with third-party reimbursement where possible, also may have affected the documentation (45,46). Assessment rates for community problems such as alcohol/drug abuse and safety risks were higher than the other sites, as were their rates of screening for diabetes and cholesterol.

The chart audit findings of family practice residency programs reflect a generally positive attitude toward prevention following graduation from medical school (47,48). These findings validate also the complaint that physicians graduate with an inability to provide counseling and patient education consistently and effectively (49,50). The residents generally followed age- and gender-appropriate screening and immunization guidelines, with best results for diabetes and cholesterol testing. Their counseling documentation was generally higher than that for community health centers but lower than that for public health clinics, reflecting perhaps the dilemma of valuing prevention counseling but lacking a system to cue and reinforce its practice.

This study has limitations. The clinical sites were self-selected either as applicants for grant funding to support clinical preventive services or, as in the cases of the public health regional clinics, volunteers. The findings cannot be generalized to Texas or the nation. We did not examine differences among the clinics of the same site types or of providers within clinics. Differences in

population served, community resources, structure, mission, and staffing capabilities affect each clinic's strengths and barriers for delivery of preventive services, and we did not study this within-group variability. Also, timeliness of blood screens, such as diabetes and cholesterol, cannot be assumed to be in response to assessment of individual high risk; many patients were screened inadvertently for these as part of larger blood panel screens.

Nevertheless, this study provides a thorough examination of medical chart documentation of a wide variety of clinical preventive services. This audit covered not only assessment of more than 11 educational topics but also counseling on those topics and timely provision of more than 8 screening tests and immunizations. We described also clinical preventive services provided in community health centers and public health regional clinics — types of sites that have not been typically included in past studies.

Documentation of clinical preventive services at these clinics did not achieve Healthy People 2000 goals, and the rates of provision vary among sites for the different health promotion topics. Clinical preventive services offered may increase in the future as a result of continuous quality improvement programs, increasing consumer demand, or the implementation of systematic prevention programs, but data indicate that achievement of the goal may require clinic-wide systems change.

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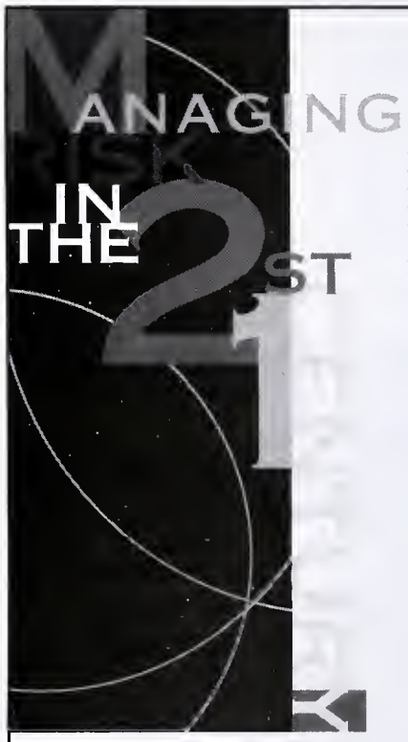
Fifth Annual Breast Care Advances and SCMIS Bioskills Training Conference, August 21-22. Sponsored by UT Southwestern Medical Center, Department of Surgery. Simmons Biomedical Research Building, UT Southwestern. Course Directors: R. Rohrich, MD; G. Peters, MD; M. Leitch, MD; E. Frenkel, MD; D. Jones, MD. CME credit offered. Contact Chelsea Yost (214) 648-2200.

The 6th Symposium on Techniques of Patient-Oriented Research, September 11. Sponsored by UT Southwestern Medical Center, The Center for Training in Clinical Investigation. Simmons Biomedical Research Building, UT Southwestern. Course Directors: P. Adams, PhD; C. Pak, MD. CME credit offered (Ethics). Contact Lisa Dunlevy (214) 648-9532.

Minimally Invasive Pediatric Surgery, September 17-18. Sponsored by UT Southwestern Medical Center and the Southwestern Center for Minimally Invasive Surgery. Simmons Biomedical Research Building, UT Southwestern. Course Directors: D. Jones, MD; S. Burdick, MD. CME credit offered. Contact Leah Cannon (214) 648-3792.

What's New in Gastroenterology & Hepatology?, September 18. Sponsored by UT Southwestern Medical Center. Renaissance Dallas Hotel. Course Directors: W. Peterson, MD; D. Thiele, MD. CME credit offered (Ethics). Contact Lisa Dunlevy (214) 648-9532.

Plastic Surgery for the Pediatrician, September 25. Sponsored by UT Southwestern Medical Center. Simmons Biomedical Research Building, UT Southwestern. Course Directors: H.S. Byrd, MD; P.C. Hobar, MD. CME credit offered. Contact Jim O'Reilly (214) 648-3794.



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Update in Sexually Transmitted Diseases, October 22-23. Sponsored by UT Southwestern Medical Center, Department of Internal Medicine. Renaissance Dallas Hotel. Course Director: J. Smith, MD. CME credit offered (Ethics). Contact Lisa Dunlevy (214) 648-9532.

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BackTalk

In June, a statement from TMA President Alan C. Baum, MD, about the AMA vote on collective negotiations for physicians (see "AMA Votes for Negotiating Unit in Stormy Session," pp 16–18) was e-mailed to about 6,500 TMA members. Dr Baum said TMA shares physicians' anger and frustrations, but regrets the AMA action. TMA prefers the approach of the Physician Negotiation Bill passed by the 1999 Texas Legislature because Texas doctors believe the ability to jointly negotiate quality of care issues is right for doctors and patients, he said. Here is a sample of some of the physicians' responses:

"I do agree with and share your concerns. As a physician, I do not want to be put in a position where I am forced to deny care to patients who have medical needs. I believe the patient-physician relationship is of paramount importance and should not be infringed upon."

John Marshall, MD, 77
anesthesiology, Houston

"Union is not a bad word. Unions helped achieve dignity for the American worker. I was a member of organized labor before I became a doctor."

W. B. Donovan, MD, 64
psychiatry, San Antonio

"All of this is for naught until we have a one-payer system. I pray that it is not an insurance company. Every plan is changed every 6 or 12 months — so often that participating physicians don't get their current plan instructions and formularies. Members of the TMA House of Delegates handled the matter with their usual collective wisdom and tact, and should be commended for a job well done!"

J. C. Burns, MD, 64
family practice, West Columbia

"I strongly support Dr Baum's statement and the TMA position. TMA is holding the 'high moral ground.' The AMA and the HMO contingent are haggling over short-term 'money issues' and are devoid of ethical or moral commitment."

Al Reinarz, MD, 64
infectious diseases, Austin

"Frankly, I'm all for a union for doctors. The business types take advantage of our oath to make huge profits, without an inkling of the practice of medicine. This is a first step."

Walter Carr, MD, 49
neurology, Frisco, Colo

"I agree 100% with TMA's position concerning a doctor's labor union. This is not professional, and it is demeaning to even think of myself as a laborer. By the way, we are not providers; rather, we are physicians, doctors, surgeons."

Melton J. Horwitz, MD, 56
otolaryngology, Houston

"Having been in academic medicine for 15 years before the past 5 years as a solo practitioner, and even though I am not an AMA member, I am supportive of its action. It is time that all available means be mobilized to actively fight!"

Robert J. Carpenter, Jr, MD, 53
obstetrics-gynecology, Houston

"We should be able to confront the insurers with a collective bargaining committee examining all contracts offered to physicians, advising and arguing in such a way that they will be in a competitive situation. Without denial of care, we could advise our patients as to which is the best insurer. Health care is a market, and it should be competitive. Our power is our patients' trust."

H.A. Epstein, MD, 84
general surgery, Dallas

Back Talk is a nonscientific sampling of Texas physicians' opinions on a topic of interest. Physicians are polled by telephone, fax, or e-mail. We welcome suggestions for future topics. Send them to *Texas Medicine*, Back Talk, 401 W 15th St, Austin, TX 78701; fax them to (512) 370-1632; or e-mail them to larry_b@texmed.org.

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Women in medicine

We've come a long way since the days when the sight of a woman physician was a curiosity. Women now rightfully work alongside their male counterparts at every level of medical practice and play an increasingly important role in the leadership of organized medicine. It's too bad the same can't be said for women physicians in academia and executive management.

By Melissa McEver

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The Journal

Rates of abnormalities and infectious agents in cervical smears from female inmates in Texas: comparison with private and university clinic patients **60**

By Roberto Logrono, MD; Jick Y. Wong, MS, CT(ASCP), MT(ASCP)

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September 1999

Legislative Affairs

Patients' bill of wrongs 24

Patients' rights collided with HMOs' rights in the US Senate this summer and the HMOs won, thanks in large part to the health plans having the support of the Republican majority. Both Republicans and Democrats played politics with the issue, and organized medicine's hopes for a fair bill now rest with the House.

By Ken Ortolon

Science

Pharmacy turf battle 28

A plan by the Texas Tech University Health Sciences Center School of Pharmacy to look at increasing the role pharmacists play in treating patients with type 2 diabetes has set off alarm bells in the physician community. Is the plan aimed at improving patient care or raising the status of pharmacists?

By Monica Maldonado

Medical Economics

Physician profiling 44

It seems like there are ratings for everything these days, from football teams to livable cities, and it's probably just a matter of time before physician rankings are a reality. The key question is, will they be used for education or for punishment?

By Laurie Stoneham

Public Health

Project WATCH 48

Like it or not, physicians are role models for their patients. If you're overweight or if you smoke, it's difficult to persuade patients to change their own behaviors. That's why Project WATCH, a new program being launched by TMA, will be important in helping you and your patients prevent cardiovascular disease and stroke.

By Laura Albrecht

Science

Why people get sick 53

We know illness can be caused by factors such as poor nutrition, contaminated water, and risky behavior like smoking and abusing alcohol or drugs. But an innovative study getting under way in Houston will look beyond disease to see if factors such as income, education, employment, and family status affect health and mortality rates.

By Monica Maldonado

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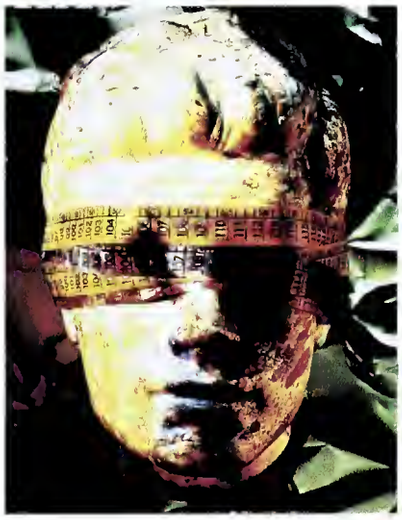

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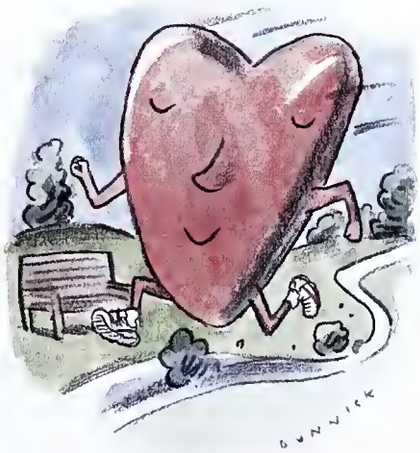

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The Big Picture

Castle Sant' Angelo, Rome, Italy, by Kayla Weitlauf, MD, Lubbock

If you would like to submit a photograph for The Big Picture, please send it to Laura J. Albrecht, Photo Editor, *Texas Medicine*, 401 W 15th St, Austin, TX 78701.

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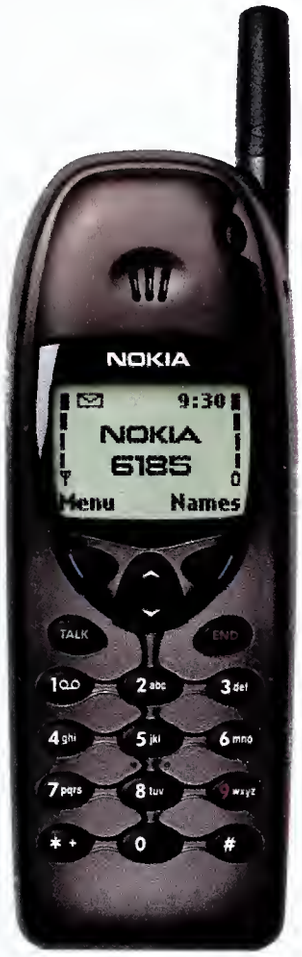

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Editor's Note

September is Women in Medicine month and in this issue we take a hard look at how far women have come in the practice of medicine and how far they still have to go. Writer Melissa McEver says progress has been made but, unfortunately, in the academic world, a woman dean or full professor is still a rarity. The same goes for the executive management side of medicine.

And, don't miss writer and historian Mike Cox's fascinating tale of Dr Sofie Herzog, the first woman surgeon in Texas. "Dr Sofie," as she was known to her patients, was as colorful as the times in which she lived.

Whenever I introduce Shari Henson to people, I always tell them she is the "brains" of the *Texas Medicine* operation. I think it embarrasses her a little, but it's true. Shari is the one who manages the complex production process of the magazine and makes sure there is a *Texas Medicine* each month. Without her, you probably wouldn't be reading this. That's why I'm pleased to report that Shari has been promoted to the position of managing editor.

Meanwhile, we've lost two staff members. Senior Editor Teri Moran has left to join the staff of Dell Computers, while Associate Editor Johanna Franke has taken her talents to the TMA Alliance, where she is director of programs. We'll miss both of them and wish them well.

Larry BeSaw
Editor

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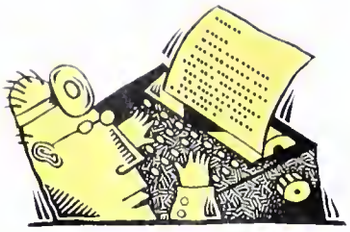

Letters

Cost versus care

I enjoyed reading the Texas workforce article regarding the appropriate complement of physicians for the patient population ("Shortage Amid Surplus," July 1999 *Texas Medicine,* pp 38–45). After thinking about it for awhile, I was reminded of a time during the mid-1980s when somebody asked me if we were having a nursing shortage. My opinion then was that we were not having a nursing shortage, it was simply that none of the nurses were nursing!

As someone in the rank-and-file physician workforce, I see more physicians — from the mid-50s on — contemplating, or at least planning, retirement as soon as possible. Many physicians also are moving into administrative positions.

However, I think the most subsurface erosion of the physician workforce is caused by physicians who are not willing to treat Medicaid or uninsured patient populations. In many physicians' offices, the front office is stacked deep with people who simply fill in the blanks on the appointment calendar and who have been instructed to send others to the emergency room. This is a very ominous trend.

In my current field of ophthalmology, more physicians are moving to refractive surgery and other types of noninsurance-driven procedures to avoid the headaches of managed care. At least in our town, it is getting harder and harder for patients to find someone to take care of them when they are sick.

Although I feel that it is only natural for physicians, just as any profession, to seek the safest ground, I do think this is an ominous trend that is being exacerbated by the lack of ability to cost-shift. This pendulum is clearly swung in favor of cost rather than care; hopefully, at some point, we will get back to the middle.

It is getting harder and harder for patients to find someone to take care of them when they are sick.

Lee S. Anderson, MD
1350 S Main, Ste 3200
Fort Worth, TX 76104

Respect needs to be earned

Dr Pettigrove criticizes physicians for a lack of moral outrage in response to what he perceives to be an era of excess materialism and the loss of virtue, idealism, and traditional values ("Where is the Outrage?" June 1999 *Texas Medicine,* p 25). He calls for physicians to heal society and guide it back toward the Biblical ideal. Although many Americans are concerned about materialism being over-emphasized, I am sure that a significant number of Americans are grateful for having good jobs and for their children having more opportunities than ever before. There's a lot to be said in favor of good economic times rather than economic depression, unemployment, homelessness, and hopelessness. Whether or not we live in depraved times is open to debate, but certainly crime is significantly decreased. If there is a moral decline, who is to say it is caused by good economic times?

Furthermore, what evidence is there that physicians are more ethical or moral than any other group of people? I can understand organized medicine taking ethical and moral stands on tobacco abuse, alcohol and drug abuse, violence, and universal health care. But I think organized medicine is on very shaky ground when it tries to moralize about our society's shortcomings. What did organized medicine have to say about slavery, racism, prejudice, and universal suffrage when these issues were crying for correction?

Express your point of view in *Texas Medicine*. To submit a letter, mail, fax, or e-mail it to *Texas Medicine*, TMA, 401 W 15th St, Austin, TX 78701; fax (512) 370-1632; e-mail larry_b@texmed.org. Please type letters you submit for publication, and keep the length to 400 words or less. If necessary, you may include a few references, preferably less than five. Letters are published at the discretion of the managing editor and editorial advisors, and are subject to editing and abridgment. Letters represent the opinions of the authors and do not necessarily reflect the policies of the Texas Medical Association.

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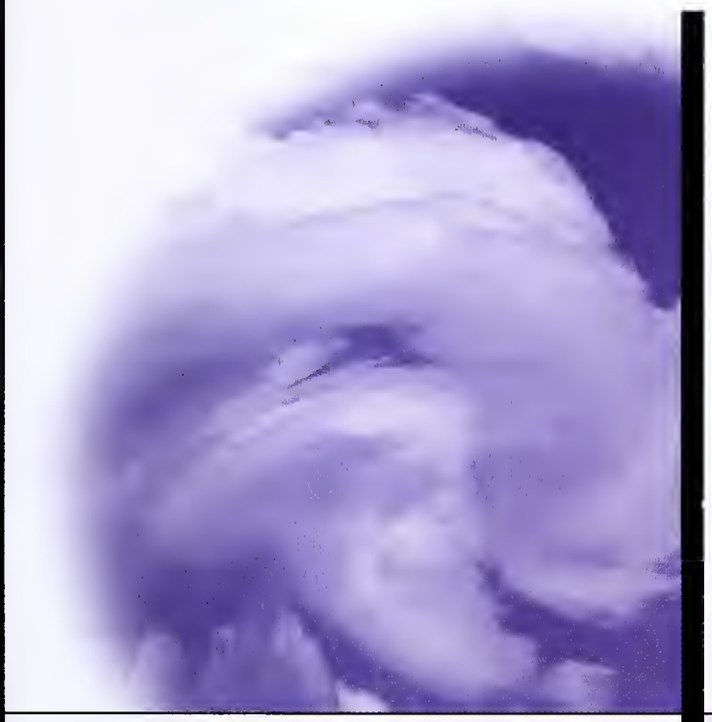
Letters

This is not to say that physicians have no right to express moral outrage. Of course, we do, just as any individual or group in our society has that right. But I believe that we need to have our own house in order before we attempt to be the nation's conscience.

Organized medicine, as I have said in this publication previously, historically opposed the establishment of health insurance and Medicare. A case can be made that managed care exists because of the vacuum created by organized medicine's resistance to universal health care. For a long time, organized medicine was in bed with the tobacco industry. And how ethical are physician-sponsored political action committees? If individual physicians and organized medicine could have a major impact on medical ethics, that truly would be a significant accomplishment. I prefer to leave the evaluation of and prescription for society's morality to others.

Attempting to be the nation's moral leader is a tremendous undertaking fraught with peril. Whoever attempts this role must come to the table with relatively clean hands. Many pretenders and hypocrites have been exposed to be mere frauds. More respect is usually extended to those who practice good deeds rather than to those who merely preach morality. Let's earn our society's respect by establishing quality universal health care. That would go a long way toward establishing our credibility as an ethical and moral force to be reckoned with in the future.

Jerry Frankel, MD
3320 Snidow Court
Plano, TX 75025



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- Informative Dawn Duster session led by Robert M. Tenery, MD, focusing on *Medical Ethics: Present Conflicts and Issues*
- Luncheon courtesy of Texas Medical Liability Trust

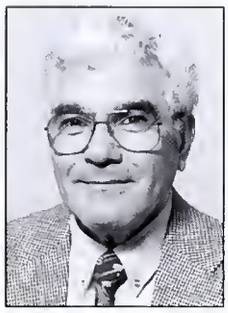
People

Newsmakers

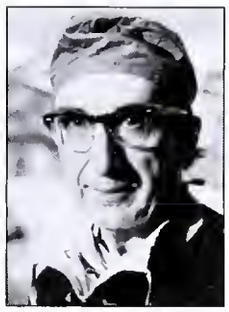
Jorge Albores-Saavedra, MD, Dallas, received a first-place award for his paper "Morphology Accurately Predicts Behavior of Mucinous Cystic Neoplasms of the Pancreas" from the gastrointestinal pathology subspecialty section of the United States and Canadian Academy of Pathology.

Dallas internist **Ron J. Anderson, MD,** was installed as chair of the 1999–2000 Texas Hospital Association Board of Trustees.

Texas A&M College of Medicine faculty and graduating students received the following honors during the college's senior banquet and commencement ceremonies: Temple obstetrician-gynecologist **Carin Appel, MD,** received the Antony Van Leeuwenhoek Award for Excellence, the Dudley P. Baker, MD Award for Excellence in Obstetrics and Gynecology, and the Henry B. Hahn, Jr Award for Outstanding Performance on a Pediatric Clerkship; **John Blevins, MD,** of Temple, was recognized as the outstanding faculty member in pediatrics; Allen internist **Wendy Brooks, MD,** received the Alpha Omega Alpha Award of the Eta Chapter of the Alpha Omega Alpha Honor Medical Society and the Healthcare Foundation of New Jersey Humanism in Medicine Award for a student; Temple internist **Christian Cable, MD,** received a Merck Award and the Department of Medicine Award, and was recognized as a "Top Pathology Student"; **Laura Connell, MD,** of Temple, received the Janet M. Glasgow Memorial Achievement Citation; family practitioner **Kip Corrington, MD,** of Greensboro, NC, received the James A. Knight Award for Excellence in Humanities in Medicine and the Richard K. Gaines, MD Award for Excellence in Psychiatry; and **Nefertiti DuPont, MD,** of Oklahoma City, received the James A. Knight Award for Leadership in Medicine.



Jorge Albores-Saavedra, MD



Michael E. DeBakey, MD

Eddie Molina-Lamas, MD

Paul C. Peters, MD

Temple pediatrician **Robert Flowers, MD,** was recognized as the outstanding resident in pediatrics; Temple general surgeon **Seth Fritcher, MD,** received the Raleigh R. White Award for Surgical Excellence; Temple family practitioner **Matthew Furman, MD,** was recognized as the outstanding resident in family medicine; Temple family practitioner **Robert Henry, DO,** was recognized as the outstanding faculty member in family medicine; **Kristopher Knoop, MD,** of Temple, received the Outstanding Student in Family Medicine Award; Harker Heights family practitioner **Kelly Maedo, MD,** received a Merck Award; Temple obstetrician-gynecologist **Chris Mason, MD,** received the Texas A&M University Corps of Cadets March of Dimes Grant and John Montgomery Travel Award for Study of History of Medicine; **Michael Dean McFadden, MD,** of Temple, received the Helen Salyer Anderson Award, the Lange Medical Publications Award, and an Award for Outstanding Performance During a Clinical Clerkship in Otolaryngology, and was recognized as a "Top Pathology Student"; and Bryan nephrologist **Richard Morgan, MD,** received the Healthcare Foundation of New Jersey Humanism in Medicine Award for a faculty member.

Temple obstetrician-gynecologist **Karen Patterson, MD,** was recognized as the outstanding faculty member in obstetrics and gynecology; **Joanne Phem, MD,** of Temple, received an

Please let *Texas Medicine* know about your honors and achievements. Criteria for inclusion in the Newsmakers section are TMA membership; election or appointment to an office of, or honors from, a national or state organization; or, space permitting, recognition at the local level. Items for the Newsmakers section are published at the discretion of the managing editor. Submit items for consideration, with photos if possible, to People, *Texas Medicine*, 401 W 15th St, Austin, TX 78701; fax (512) 370-1632; e-mail larry_b@texmed.org.

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People

Award for Outstanding Performance During a Clinical Clerkship in Otolaryngology; Temple internist **Salman Razi, MD,** was recognized as the outstanding resident in internal medicine; Temple general surgeon **Randall Smith, MD,** was recognized as the outstanding faculty member in surgery; and Temple obstetrician-gynecologist **Len Tadvick, MD,** was recognized as the outstanding resident in obstetrics and gynecology.

Houston cardiothoracic surgeon **Michael E. DeBakey, MD,** received an honorary doctor of science degree from Wake Forest University.

Houston general surgeon **Jeremy W. Denning, MD,** was recognized as one of two graduates to receive a 4.0 grade point average at The University of Texas-Houston Health Science Center's commencement ceremony. Dr Denning received awards from the Departments of Biochemistry, Microbiology, Clinical Medicine, Pharmacology, Physical Diagnosis, and Pathology/Laboratory Medicine.

The 1999–2000 Texas Transplantation Society officers include El Paso general surgeon **Hector Diaz-Luna, MD,** president; San Antonio general surgeon **Glenn Halff, MD,** president-elect; Austin general surgeon **Michael Mueller, MD,** heart councilor; and Dallas abdominal surgeon **Robert Goldstein, MD,** liver councilor.

Eddie Molina-Lamas, MD, a Houston anesthesiologist, was elected to the Board of Directors of the Society for Obstetric Anesthesia and Perinatology.

Houston infectious disease specialist **Barbara E. Murray, MD,** received the 37th Annual Marion Spenser Fay National Board Award of MCP Hahnemann University.

Orthopedic surgeon **Brian S. Parsley, MD,** received the Outstanding Medical Professional Award from the Arthritis Foundation-Houston.

Dallas urologist **Paul C. Peters, MD,** was elected president-elect of the North Texas Chapter of the American College of Surgeons.

Geoffrey L. Robb, MD, Houston, was elected chair of the Department of Plastic Surgery at The University of Texas M.D. Anderson Cancer Center.

Tibor Ruff, MD, of Temple, was elected president of the Texas Association of Otolaryngology.

General surgeon **Ronald Stewart, MD,** received Faculty of the Year honors from The University of Texas Health Science Center at San Antonio.

Obstetrician-gynecologist **Margaret Thompson, MD,** won the Austin Ernst & Young Services Entrepreneur of the Year Award for her work with the Renaissance Women's Center and was nominated for the national award competition.

Deaths

Charles Edward Beachley, Jr, MD, 75; Lewisville; Harvard Medical School, 1947; died March 20, 1999.

Walter Ira Berman, MD, 52; Dallas; University of Mississippi School of Medicine, 1972; died June 27, 1999.

Albert Leonard Blakes, MD, 62; Euless; The University of Texas Medical Branch at Galveston, 1963; died May 26, 1999.

Robert Lewis Duff, MD, 81; Tyler; The University of Texas Medical Branch at Galveston, 1945; died June 9, 1999.

Jack Dunn, Jr, MD, 74; Lubbock; The University of Texas Medical Branch at Galveston, 1948; died June 14, 1999.

Joe Bill Ellis, MD, 79; Fort Worth; Baylor College of Medicine, 1951; died June 26, 1999.

Jesse Durward Gomillion, Jr, MD, 75; Houston; The University of Texas Medical Branch at Galveston, 1947; died June 28, 1999.

People

Edwin Bulian Hibbs, Jr, MD, PhD, 58; Bay City; The University of Texas Medical School at San Antonio, 1978; died February 2, 1999.

Joseph MacGalashan Hill, MD, 94; Dallas; State University of New York at Buffalo School of Medicine and Biomedical Sciences, 1928; died May 21, 1999.

Daniel Mark Ingraham, DO, 50; Bedford; College of Osteopathic Medicine and Surgery-Des Moines, 1976; died June 22, 1999.

Peter John Julian, MD, 74; Dallas; State University of New York at Buffalo School of Medicine and Biomedical Sciences, 1947; died June 17, 1999.

Howell S. McCreary, MD, 66; Gainesville; The University of Texas Southwestern Medical School at Dallas, 1958; died May 26, 1999.

Bedford Forrest Pace, MD, 89; Beaumont; University of Tennessee College of Medicine-Memphis, 1934; died June 24, 1999.

Beverly Lee Reynolds, MD, 76; Dallas; University of Virginia School of Medicine, 1952; died May 21, 1999.

Jackson Ewell Upshaw, MD, 83; Corpus Christi; The University of Texas Medical Branch at Galveston, 1942; died July 1, 1999.

Frederik Mario Wessels, MD, 81; Austin; University of Cordoba-Argentina, 1945; died June 25, 1999.

Robert James Wise, MD, 81; Houston; Washington University School of Medicine-St Louis, 1943; died June 17, 1999.

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Texas Medicine Rounds

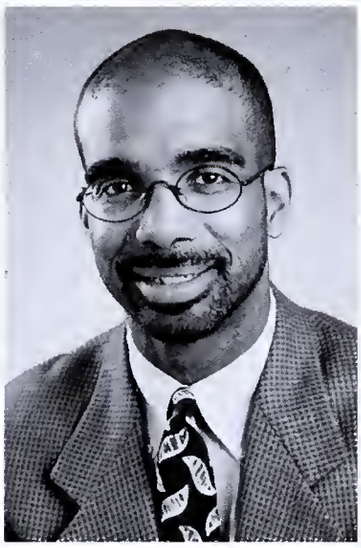
September 18 fall conference to discuss medicine's turning points

Is it really a "doctors' union"? Learn the truth behind the headlines as the president of the American Medical Association discusses the recent AMA decision to form a collective negotiating unit at Texas Medical Association's 1999 Fall Conference. Information on a wide variety of topics ranging from medical ethics to fighting cardiovascular disease will be available to physicians attending the conference, entitled "Turning Points in Medicine," Saturday, September 18, at the Renaissance Austin Hotel.

Information on a wide variety of topics ranging from medical ethics to fighting cardiovascular disease will be available to physicians attending the conference, entitled "Turning Points in Medicine."

Among those scheduled to speak are AMA President Thomas R. Reardon, MD; Clyde W. Yancy, Jr, MD, director of the Congestive Heart Failure Program at The University of Texas Southwestern Medical School; and John M. Eisenberg, MD, director of the Agency for Health Care Policy and Research.

Thomas R. Reardon, MD



Clyde W. Yancy, Jr, MD

John M. Eisenberg, MD

Robert M. Tenery, Jr, MD

The general session of the conference begins at 9:30 am with introductory remarks from TMA President Alan C. Baum, MD, after which Dr Reardon will give the keynote speech, "Turning Points in Medicine."

Dr Yancy will help kick off TMA's cardiovascular screening program known as Project WATCH by delivering a speech titled "WATCHing Points and Saving Lives . . . Including Your Own." He will encourage physicians to do a better job of screening their patients for cardiovascular disease.

Project WATCH is a 2-year cardiovascular disease and stroke prevention education program focusing on the five risk factors — weight, alcohol, tobacco, cholesterol, and high blood pressure (see "Heart to Heart," pp 48–51).

Dr Eisenberg will outline the role physicians and professional associations can play in enhancing the quality of care and improving patient outcomes.

Also during the conference, Robert W. Sloane, Jr, MD, of Fort Worth, chair of the TMA Council on Legislation, will review the recent session of the Texas Legislature. His presentation will include a review of the Texas approach to joint physician negotiations.

In addition, Dr Baum will present the "Texas Medicine's Best" awards to several state officials for their efforts on behalf of patients and physicians. Recipients are Lt Gov Rick Perry; Sens J.E. "Buster" Brown (R-Lake Jackson), Chris Harris (R-Arlington), Jane Nelson (R-Flower Mound), and David Sibley (R-Waco); and Reps Garnet Coleman (D-Houston), Craig Eiland (D-Galveston), Patricia Gray (D-Galveston), Kyle Janek (R-Houston), Glenn Lewis (D-Fort Worth), John Smithee (R-Amarillo), and Barry Telford (D-DeKalb).

A "dawn duster" session will begin the day's activities at 7:45 am with a presentation by Robert M. Tenery, Jr, MD, of Dallas, immediate past chair of the AMA Council on Ethical and Judicial Affairs. He will focus on medical ethics conflicts and issues.

The conference also includes a luncheon hosted by the Texas Medical Liability Trust (TMLT), during which John Daly, PhD, the entertaining Amon Carter professor of communications at The University of Texas at Austin, is scheduled to discuss "So You Think You're Communicating?"

The day's events will conclude with a risk management seminar, "Was It Something I Said? The Underlying Psychology of Medical Malpractice," from 2 to 4 pm. The fee for the seminar is $85 for TMA members, but it is reduced to $65 for members insured by TMLT.

The remainder of the conference is free to TMA members. It is designated for 5 hours of AMA Physician's Recognition Award Category 1 continuing medical education credit. On-site child care is available.

To register, call Amy Edwards, TMA special services, at (800) 880-1300, ext 1346, or (512) 370-1346; or e-mail amy_e@texmed.org. ★

Road show offers insight to Internet health care

Physicians interested in incorporating the Internet into their medical practices can get a first-hand look at how the World Wide Web is changing health care with a free, all-day training session, the "Internet Health Road Show," Friday, September 17, at the Renaissance Austin Hotel. Held in conjunction with the Texas Medical Association's 1999 Fall Conference, the session is sponsored by TMA, the American Medical Association, and Intel.

The event, an AMA and Intel pilot program of a mobile presentation AMA hopes to take to physicians throughout the nation, will cover topics such as emerging Internet trends, barriers to physician use of the Internet, and patient use of the Internet.

Physicians who attend the session will be able to:

- Understand the direction the Internet is pushing the patient-physician relationship, the health care industry, and the health information process;
- Identify major types of Internet consumer health sites and applications and become familiar with the features provided by Internet tools developed for physicians in clinical, office management, and educational settings; and,
- Understand the limitations of current Internet tools.

Expert speakers will include Steve McGeady, vice president of Content Group and director of Intel's Internet Health Initiative; Thomas Ferguson, MD, adjunct professor of health informatics at The University of Texas-Houston Health Science Center; Richard E. Corlin, MD, speaker of the AMA House of Delegates; Robert Sikorski, MD, PhD, chair and chief technology officer of Mednav.com Inc; and Robert McKinstry, MD, PhD, assistant professor of neuroradiology for the Mallinckrodt Institute of Radiology and the Washington University School of Medicine.

The activities begin with novice Internet training from 8 to 10 am. The formal presentations begin at 10 am with Mr McGeady discussing the Internet's impact on health care. That will be followed by discussions of the Internet's role in health care and barriers to physicians' using the Web, how patients are leading the online revolution, physicians' reaction to patients on the Internet, working with Web-savvy patients and how doctors can benefit, and how the Internet increases a medical practice's efficiency. The presentations will include "hands-on" use of personal computers.

The session will conclude with a networking reception from 4:30 to 7 pm. The reception is open to all physicians who attend the Internet road show and the TMA Fall Conference.

AMA has designated the event for up to 7.5 hours of AMA Physician's Recognition Award Category 1 continuing medical education (CME) hours. While the session is free, a $25 CME processing fee will be charged.

To register, call Paula Rigling at (800) 880-1300, ext 1450, or (512) 370-1450; or e-mail paula_r@texmed.org. ★

Border programs screens for acanthosis nigricans

A pilot program to screen children attending school in nine border counties for acanthosis nigricans, a skin condition associated with insulin resistance and a propensity for type 2 diabetes, has been created by the Texas Legislature. The program requires school nurses to screen children for acanthosis nigricans at the same time that vision, hearing, and scoliosis screenings are performed.

Schools will be required to notify parents of children identified as having acanthosis nigricans and recommend that they be seen by a physician. Physicians in the participating counties — El Paso, Hudspeth, Cameron, Hidalgo, Jim Hogg, Starr, Webb, Willacy, and Zapata — undoubtedly will receive referrals from the screening program.

Medicaid will reimburse physicians for treating acanthosis nigricans and will pay for one evaluation and four consultations with a dietitian.

The 2-year pilot program will be coordinated by The University of Texas System Texas-Mexico Border Health Coordination Office in Edinburg. For more information, call (956) 381-3687, fax (956) 381-3688, or e-mail pvillas@panam.edu. ★

UT-Houston creates surgery department

The University of Texas-Houston Medical School has established a new department of cardiothoracic and vascular surgery with the help of Hermann Hospital, a $20 million endowment, and the former head of Baylor College of Medicine's Division of Vascular Surgery.

Hazim Safi, MD, was hired away from Baylor to become the chair designate of the new department as well as chief of the cardiothoracic and vascular surgery service at Hermann Hospital, according to a July 5 *Houston Business Journal* article. ★

TMA expands speakers' bureau

The Texas Medical Association recently expanded its speakers' bureau by recruiting physician volunteers from across the state to relay TMA priority issues to various medical groups. TMA will provide a speaker to any physician group, including county medical societies, state medical specialty societies, TMA sections, hospital medical staffs, allied health professionals, and medical schools, for free.

Topics to choose from include recent legislative victories, rural health, physician workforce, major liability issues, TMA relevance and values, and the Children's Health Insurance Program.

Physicians who want to schedule a speaker for their next meeting or who wish to join the bureau and speak on one of these topics may register with the TMA Speakers' Bureau by calling (800) 880-1300, ext 1375, or (512) 370-1375; or by sending an e-mail to jennifer_o@texmed.org. ★

Drs Evans, Varma join editorial committee

Carolyn A. Evans, MD, and Surendra K. Varma, MD, have been appointed to the *Texas Medicine* Editorial Committee by the Texas Medical Association Board of Trustees.

Dr Evans is a Plano pediatrician and former chair of the TMA Council on Communication. Dr Varma is professor and vice chair of pediatrics and director of the Pediatric Residency Program at the Texas Tech University Health Sciences Center School of Medicine in Lubbock.

Both physicians will serve 3-year terms on the 15-member committee that sets broad policies for *Texas Medicine* and reviews clinical articles submitted for publication in the Journal section of the magazine. ★

Extra! Extra! Read all about it

Confused over the myriad health plans from which you and your patients have to choose? Help is available. "Essential Elements of a Quality Plan" has been produced by the TMA Council on Socioeconomics and Council on Communication to help physicians and patients better judge the health plans with which they have to contract or in which they may enroll. The combination of a four-color poster for patients and a detailed matrix for physicians provides an objective yardstick for measuring the various health plans.

The backbone of the poster and matrix is the Essential Characteristics of a Quality Health Plan, devised in 1987 by the American Medical Association Center on Society Sponsored Managed Care Corporations.

To ensure their accuracy and completeness, the poster and matrix were reviewed by the TMA Medical Directors' Forum, the Texas Association of Health Plans, the medical directors of several Texas health plans, the Texas commissioner of insurance, and the Texas office of a national consumer protection organization.

The poster and matrix were printed in a special pullout section between pages 48 and 49 of the May 1999 issue of *Texas Medicine*. TMA members can use a postcard in that same issue to order up to four additional copies for free. Sets of 10 are available for $20, tax and postage included. If you do not have the postcard, you may place an order by calling (800) 880-1300, ext 1390, or (512) 370-1390; sending a fax to (512) 370-1632; or sending an e-mail to steve_l@texmed.org.

In addition, members may call the Texas Department of Insurance publication order line at (800) 599-7467 to order up to 25 free copies of the brochure/complaint form "Helping You With Your Insurance Complaint" for distribution to patients. ★

WEB SITES OF INTEREST TO TEXAS PHYSICIANS BY JOHANNA FRANKE

MedBytes

September's "MedBytes" serves up medical sites with Texas connections.

The Ferguson Report

Austin physician Thomas Ferguson, MD, has been publishing "The Ferguson Report: The Newsletter of Online Health" on the Internet at ferguson-report.spark list.com since March. In monthly reports for physicians, Dr Ferguson, adjunct associate professor of health informatics at The University of Texas-Houston Health Science Center, focuses on online health, industry trends, company profiles, upcoming meetings, and ways to respond to Internet-savvy patients. To subscribe, send an e-mail to ferguson-report-request@sparklist.com. To learn more about the reports, attend the "Internet Health Road Show" on September 17 in conjunction with Texas Medical Association's 1999 Fall Conference in Austin.

Physician's News Digest

Who knew a Texas medical news service could be based in Pennsylvania? Jeffrey Barg, editor and publisher of Physician's News Digest (PND), did. The site at physiciansnews.com has carried Pennsylvania medical news focusing primarily on health policy, medical economics, and health care law since 1996. Recognizing the swift changes in Texas' health care environment, PND producers expanded their updates to include the Lone Star State. Subscribe to the Texas edition of "PND News Briefs," an e-mail service, at physiciansnews.com/about.html#subscription.

Texas Physicians Database

For historical information on Texas doctors, go to www.swmed.edu/home_pages/library/doctors/doctors.htm. The searchable database, which includes biographical information dating back between the years 1870 and 1966, was built by The University of Texas Southwestern Medical Center at Dallas Library.

Dr Koop's health network

Austin-based drkoop.com provides health information and resources for the whole family. Inspired by C. Everett Koop, MD, former US surgeon general, the site strives to improve the quality of people's lives by empowering them to improve their health.

Physicians Who Care

The not-for-profit National Organization of Physicians Who Care (PWC), based in San Antonio, was formed in 1985 to protect the patient-physician relationship. The PWC Web site at www.pwc.org delivers legislative alerts and provides Medicare+Choice updates, news articles on topics such as patient rights, and information on state health care reform. PWC also sponsors "The HMO Page" at www.hmopage.org, which houses physician and consumer experiences with managed care plans, and "The MSA Page" at www.msapage.org, which contains medical savings account information.

TMA's Cyber Sweepstakes hits September

Be sure to drop by the TMA Web site at www.texmed.org before September 30 to sign up for TMA's latest Cyber Sweepstakes. TMA members who provide or confirm their e-mail addresses through the "Members Only" section before the end of this month are entered automatically to win a Palm V ultrathin organizer with razor-sharp LCD screen. Your e-mail address will be used to contact you with breaking health care news.

MedBytes is a quick look at new, or newly discovered, Web sites of interest to Texas physicians. The column also highlights features of the TMA Web site at www.texmed.org. If you know of some cool medical sites or have questions about how to use the TMA Web site, e-mail larry_b@texmed.org. Publication of information about Web sites in this column is not to be considered an endorsement or approval by the Texas Medical Association of the sites or sponsors, or of any products or services involved.

WHAT YOUR PATIENTS ARE READING

Dateline: Health

By Laura Albrecht

The following is a collection of recent consumer magazine articles that feature health and medical information. Send suggestions and comments to Laura Albrecht, *Texas Medicine*, 401 W 15th St, Austin, TX 78701; or e-mail laura_a@texmed.org.

"AMERICA'S BEST HOSPITALS." Take a look at the top hospitals in the country in 16 different specialties. *US News & World Report*, 7/19/99

"THE ARKANSAS HEALER." A gifted surgeon in Arkansas takes on the toughest cases. *US News & World Report*, 7/19/99

"INFECTION CONNECTION." Do viruses and bacteria cause mental illness? *Psychology Today*, 8/99

"A CHUCKLE A DAY . . . WHY LAUGHING IS GOOD FOR YOU." Adults are laughing 15 times a day while a typical kindergartner laughs up to 300 times. Physicians share their views on the health benefits of a case of the giggles. *Family Circle*, 8/99

"THE HEALING POWER OF PETS." Patients with Alzheimer's disease, nursing home residents, and sexually abused teenagers benefit from the unconditional love of animals. *Family Circle*, 8/99

"WHO'S READING YOUR MEDICAL RECORDS?" Experts say 80 to 100 individuals have access to patient records. Learn how insurance companies are snooping in medical records and where the medical information goes. *Good Housekeeping*, 8/99

"MOM, I'M PREGNANT." Mothers reveal how they handled their teenage daughters' pregnancies. *Ladies' Home Journal*, 8/99

"WHEN TO CALL 911." When do you call and what happens when you call for emergency assistance? Physicians provide sound advice to calm even the most panic-filled parents. *Parents*, 8/99

"OUTSMARTING ALZHEIMER'S." Four million Americans suffer from Alzheimer's disease. Treating or preventing the disease with a vaccine provides hope for patients. *Newsweek*, 7/19/99

Physician stress/burnout course updated

The Texas Medical Association Committee on Physician Health and Rehabilitation (PHR) recently updated the course "Physician Stress/Burnout" to include suggestions made by previous participants. Specifically, more solutions are offered, recommending specific ways a physician can manage the stress in his or her life.

The course is given by PHR committee regional education team members to county medical societies, hospitals, and other groups, at no charge, upon request. It also is available on the Internet at www.texmed.org under "Education/CME," and as a home study course. Even for those who have previously taken this course, the revised program is an excellent refresher.

The "Physician Stress/Burnout" course is one of a series offered by the PHR committee. Other topics include "Alcohol & Other Drug Use Among Physicians," "Intervention for Physicians Who May be Impaired," "How to Establish a Peer Assistance Committee," and "Care for the Caregiver (Behavioral & Emotional Problems)."

All of the PHR courses have been designated for 1 hour of Category 1 credit of the American Medical Association Physician's Recognition Award. TMA also has designated these courses as ethics/professional education.

To request a course or for additional information, contact Linda Kuhn at (800) 880-1300, ext 1342, or (512) 370-1342; or e-mail linda_k@texmed.org. ★

Aetna involved in Florida, Virginia disputes

This probably won't come as a surprise, but Texas physicians are not alone in their problems with Aetna US Healthcare. *The Orlando Business Journal* reported in July that several Central Florida physicians are refusing to renew their Aetna contracts because of its "all products" provision that does not allow physicians to contract with any Aetna

insurance program unless they contract with all programs offered in the market. Aetna has extended its physician contract renewal deadline to September and has told employers it plans "intense meetings" with doctors to encourage them to sign.

Meanwhile, the *Washington Business Journal* says Mary Washington Hospital of Fredericksburg, Va, is suing Aetna's Mid-Atlantic NYLCare Health Plans over $3 million in unsettled and unpaid claims. The hospital sued after a year of unsuccessful attempts to resolve the dispute. Hospital officials allege NYLCare continued to wrongfully delay and deny payments despite signing a memorandum of understanding in which it promised to pay claims within 30 days, the *Business Journal* reported. ★

Health spending to grow more slowly than expected

The Health Care Financing Administration (HCFA) has lowered its projections for national health spending over the next decade from the estimates it made last year. The new projections show the rate of growth slows to an average of 6.5% during 1997–2007, compared with last year's projection of 7%. National health spending is still projected to double in level by 2008.

This new estimate reflects slower than expected growth in Medicare spending in 1998, and slower projected growth for both private and Medicare spending in the latter half of the projection period, HCFA officials say.

The study projects the nation's total health spending will reach $2.2 trillion and 16.2% of the Gross Domestic Product (GDP) in 2008, up from $1.1 trillion and 13.5% in 1997. In last year's projection, health spending was projected to reach 16.6% of GDP in 2007.

Detailed information on the forecast, both by type of service and source of funds, is available on the HCFA Web site at www.hcfa.gov/stats/nhe-proj/. ★

SUMMARIES OF RECENT HEALTH CARE FINDINGS

In Case You Missed It

By Jennifer Ownby

Use of atenolol to treat hypertension in pregnancy appears to have adverse fetal and obstetric effects, and these are most pronounced with earlier and prolonged use. *American Journal of Hypertension*, 6/99

An experimental nasal spray, called FluMist, is effective in preventing the flu in healthy adults, researchers say, and could make it to the market as early as next year. *Journal of the American Medical Association*, 7/14/99

After prostatectomy for prostate cancer, biochemical control and disease-free survival are better among patients who undergo adjuvant radiation therapy for adverse pathologic findings than among those who undergo salvage radiation therapy. *Urology*, 7/99

Americans take for granted they'll get a blood transfusion whenever they need one, but soon that may not be the case. Blood donations are dropping so low that serious, nationwide shortages could hit as early as next year. *Associated Press*, 6/28/99

High rates of HIV infection in certain regions may thwart efforts to eradicate measles, British and American investigators report. *Clinical Infectious Diseases*, 7/99

Doctors and psychologists are bracing themselves for an increase in mental breakdowns related to the end of the century. They report the number of patients suffering from stress, panic attacks, and depression linked to the arrival of the year 2000 has doubled in the past 6 months. *New York Times Syndicate*, 6/28/99

Serial creatine kinase-MB (mass) measurements can be used to determine within 7 hours of the onset of chest pain whether a patient has experienced acute myocardial infarction. *European Heart Journal*, 7/99

Body size and blood pressure are rising among US adolescents between the ages of 10 and 14, according to results of a 10-year Minnesota-based trial. *Reuters*, 6/29/99

Psychological stress seems to be a risk factor for infertility only in women with long menstrual cycles, a team of Danish researchers reports. *Fertility and Sterility*, 7/99

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Use the following prefixes plus @texmed.org to e-mail for TMA resources.

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Home HIV test kits not reliable, FTC warns

If your patients tell you they used a home test kit being sold on the Internet to check their HIV status, tell them they probably should get a legitimate test. They may have gotten some bad information.

The Federal Trade Commission (FTC) has issued an alert that some home-use test kits can give false information. The FTC recently tested HIV kits advertised and sold on the Internet and in every case, the kits showed a negative result when they should have shown a positive one.

Although the Internet ads say the kits are available only outside the United States, consumers here have been able to purchase them. Some of the ads say or imply the kits have been approved by the World Health Organization (WHO), but WHO does not approve or license such kits.

The US Food and Drug Administration has approved only one home test kit for sale in the United States. The Home Access Express system allows consumers to collect a blood sample at home, but it must be sent to a laboratory for analysis. ★

Symposium readers earn CME credit

Physicians who read the special Symposium on Environmental Medicine in the October issue of *Texas Medicine* will be eligible for 2 hours of AMA Physician's Recognition Award Category 1 continuing medical education (CME) credit. *Texas Medicine* is the first state medical society magazine to offer CME credit.

The October issue was approved for CME credit by the Texas Medical Association Committee on Continuing Medical Education as part of TMA's overall CME program, which recently received a 6-year accreditation from the Accreditation Council for Continuing Medical Education. Physicians can receive CME credit by reading the articles any time within a year after the October issue is published and returning an evaluation form that will be included in the magazine.

CME credit also can be earned by reading the articles on the TMA Web site at www.texmed.org.

"*Texas Medicine* recognizes the importance of continuing medical education, not just as a requirement for licensure but as an integral part of the practice of medicine," said John C. Jennings, MD, of Amarillo, chair of the magazine's Editorial Committee. "The symposium issues of our journal target topics that are particularly applicable to the practice of Texas physicians. By offering CME credits for these issues, we hope to encourage critical examination of areas that are important to a majority of our readership, while simultaneously making it easy to obtain CME."

Jeffrey L. Levin, MD, MSPH, is the guest editor of the issue. Dr Levin is professor and chair of occupational and environmental medicine at The University of Texas Health Center at Tyler. In addition to his commentary, "Symposium on Environmental Medicine: Into the Next Millennium," the issue will contain the following articles:

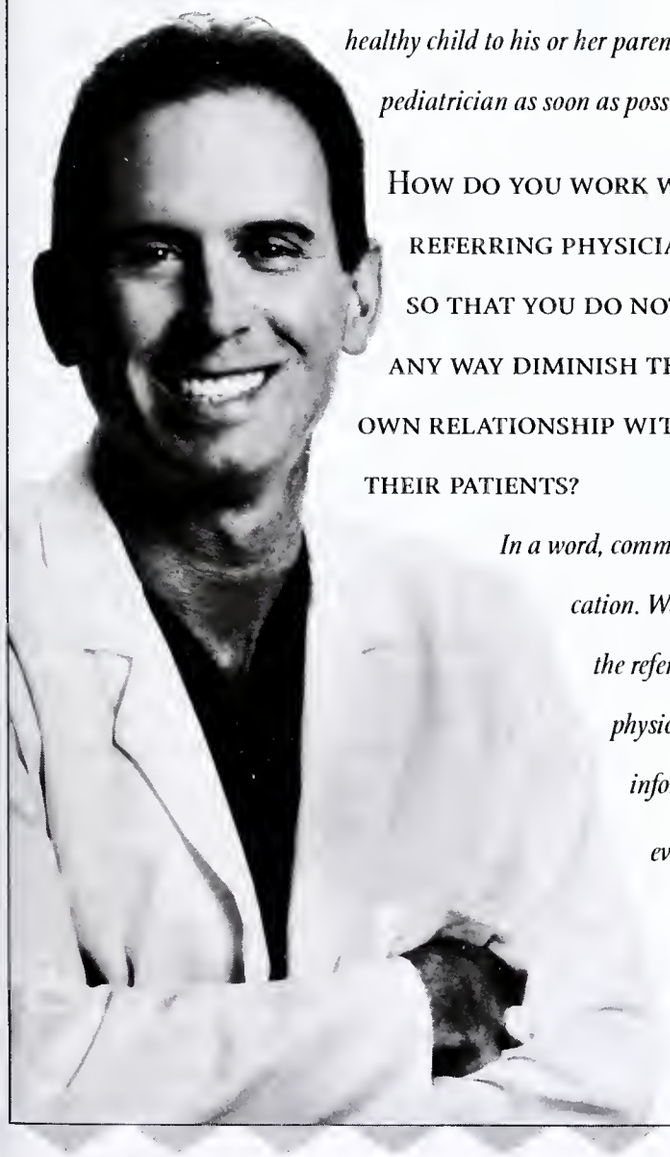
- "Environmental Awareness Among Physicians: What Are Environmental Health and Environmental Medicine?"
- "Physicians Have an Important Role in Environmental Issues."
- "The Role of Research in Environmental Science and Health."
- "The Alphabet Soup of Environmental Regulations."
- "Environmental Health Issues Along the United States-Mexico Border: an Airshed in Evolution."
- "Occupational Asthma."
- "The Texarkana Mercury Incident."
- "The Silent Voice of Reason." ★

The Expertise Referring Physicians Have Come To Count On: Cook Children's Talks With Dr. Lawrence Fox.

Dr. Lawrence Fox — Medical Director Of Cardiovascular Surgery

Dr. Fox, you are one of only a few pediatric cardiovascular surgeons in the U.S. who perform corrective surgery for hypoplastic left heart syndrome. As you work with referring physicians, what is it that prompts them to continue to refer patients to you for this and other pediatric heart problems?

The child's primary care physician knows we're committed to delivering the highest quality care, and that we have the expertise and technology to do things other hospitals can't. Our goal is to return a healthy child to his or her parents and pediatrician as soon as possible.



How do you work with referring physicians so that you do not in any way diminish their own relationship with their patients?

In a word, communication. We keep the referring physician informed every step of the way. After the operation is done, the primary care doctor gets a call and a letter, and the same occurs on the day of the patient's discharge. Also, our nurses make sure to keep the referring physician informed about any changes in the patient's condition.

What do referring physicians think are the keys to excellent pediatric specialty care?

They want to see us care for the patient's problem with a good result and return the patient to them promptly. Referring physicians also know that we do a lot of surgeries at Cook Children's, and it's like anything else – the more you do, the better the outcomes. Another thing they appreciate is the fact we have a cardiac support group that helps reduce the stress of families and everyone involved.

Can you relate an interesting case which exemplifies the trust of referring physicians in your specialty care here at Cook Children's?

Yes. A baby was born with a condition known as transposition of the great arteries, which means the position of the heart's major arteries needs to be "switched." If uncorrected, most babies will die in the first few weeks of life. The referring physician knew we performed many of these complex operations with a very high level of success, and was therefore calling to have our team care for his patient.

Cook Children's Medical Center is located in Fort Worth, Texas. For more information on Dr. Fox and his partner in Cardiovascular Surgery, Jeffrey Heinle, call 1-800-COOK517.

CookChildren's
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Patients' bill of wrongs

US Senate puts HMOs in the driver's seat with managed care reforms

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It's one of the oldest cliches in politics, but people are still fond of saying the two things you don't want to see made are laws and sausages. That may be particularly true of the process by which the US Senate crafted a so-called "Patients' Bill of Rights" in mid-July.

After months of posturing and 4 days of lengthy and sometimes heated debate, the Senate passed managed care legislation drafted by the Republican majority. The bill, offered sight unseen by all but a few Republican senators and, presumably, the health plan lobby, passed as a complete substitute for the Democratic version on almost a straight party line vote. Republicans told angry Democratic senators that they did not get copies of the bill before the vote because the copiers had broken down. ➤➤

By Ken Ortolon, Associate editor

Observers say the Patients' Bill of Rights debate was one of the most intensely partisan battles they've witnessed in Congress. And numerous Washington insiders expressed disgust over the way both parties put politics above policy.

The outcome had to please managed health care plans and their business allies, who fought tooth and nail to keep substantive managed care reforms off the Senate floor. The bill already has been dubbed an "HMO Bill of Rights."

Meanwhile, physicians say patients will be the big losers if the Senate Republican bill ever becomes law.

"I think it's a devastating setback for what we've been able to do to improve the health care climate for patients here in Texas," Texas Medical Association President Alan C. Baum, MD, of Houston, said of the Senate bill.

Dr Baum expressed little optimism the US House of Representatives can produce a better product. Even if more substantive reforms were to come out of the House, TMA lobbyists say that might only set the stage for a bitter fight to reconcile House and Senate bills in conference committee.

Still, an effort is under way in the House to cut through the partisanship that has been displayed on the managed care reform issue. A group of moderate Republicans, led by a handful of doctor-lawmakers, will attempt to craft a consensus patient protection act and get it to the floor of the House later this year. The outlook for their proposal is mixed, but the lawmakers say they are encouraged by the willingness of at least one key House committee chair to consider their proposal.

Setting the stage

The tone for July's Senate debate actually was set in 1998 when House and Senate Democrats introduced Patients' Bill of Rights legislation. The Republican majority kept the bill from moving for months but finally bowed to public opinion.

"I think there was so much attention placed on the Patients' Bill of Rights then that the Republican majority in the House — under the pressure of public opinion — finally decided they were going to have to do something," said Connie Barron, TMA's associate director for legislative affairs.

Republican leaders countered by appointing a GOP task force to look at the issue. The task force met behind closed doors for several months before unveiling a managed care reform plan that was a health plan executive's dream. The bill included no accountability for health plans that make negligent medical necessity decisions and gave health maintenance organizations (HMOs) the right to choose the reviewer in what was supposed to be an independent appeals process.

After the Senate was shut down for 4 days, the Republican leadership agreed to allow floor debate on the measure. This is where, observers say, the process and the motives of senators from both parties became somewhat convoluted. Republican majority and Democratic minority leaders agreed to rules for the debate that allowed Majority Leader Sen Trent Lott (R-Miss) to author the "underlying bill." That meant Republicans could choose which bill would be the starting point for the debate. The parties also agreed to limit debate to 4 days, with time limits for debate on each amendment offered.

"I think it's a devastating setback for what we've been able to do to improve the health care climate for patients here in Texas."

The bill, sponsored by now-Speaker of the House Dennis Hastert (R-Ill), passed on virtually a straight party line vote. Only 12 Republicans — including Texas Reps Henry Bonilla, of San Antonio, Ron Paul, of Surfside, and Kevin Brady, of The Woodlands — voted against it.

Fortunately for physicians and patients, the bill floundered in the Senate, never making it to the floor for debate. Unfortunately, virtually the same bill was trotted out again this year to counter Democrats when they again filed their version of the Patients' Bill of Rights, which closely resembles the patient protection laws enacted in 1997 by the Texas Legislature.

Forcing the issue

This time, Speaker Hastert promised a full and open committee markup of managed care reforms. Despite that promise, however, the legislation languished in both chambers. Senate Democrats finally forced the issue by virtually stalling all work in the Senate for several days.

"In an attempt to get the bill heard and get the issues debated publicly, Senate Democrats began trying to add provisions of their Patients' Bill of Rights onto various appropriations bills," Ms Barron said. "Every time they would put an amendment on, the Republicans would vote it down. Then the Democrats would try to put it on again. This was just tying up the process."

Everyone assumed Senator Lott would lay out the Republican bill, with its weak patient protections, as the underlying bill. But, in a somewhat surprising move, the bill he laid out as his own was the Democratic Patients' Bill of Rights measure. Ms Barron says that was a maneuver designed to stifle the amendment process and limit an open discussion of the issues by giving Democrats nothing to amend. One Senate staff member close to the debate, who asked not to be identified, says it also gave the Republicans the chance to be on the offensive, rather than having to defend each provision of their bill.

"But the very first amendment the Democrats offered was to replace the underlying bill with the Republican bill so that they could go ahead with their amendment strategy," Ms Barron said. That failed, as did every other Democratic attempt to amend the bill.

Once the Democrats were out of amendments, Republicans offered their original bill as a complete substitute for

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the measure that had been laid out by Majority Leader Lott. That bill passed on July 15 by a 53-47 margin. The outcome again was a straight party line vote with only Sens John Chafee (R-RI) and Peter Fitzgerald (R-Ill) breaking GOP ranks.

The bill that passed does grant some new rights for patients. Health plans would be required to pay for reasonable emergency room care and women would be able to see an obstetrician-gynecologist without a referral. However, 48 million Americans are covered by so-called "self-funded" plans offered by large employers, but only an estimated 10% of them would benefit from the Senate bill. And, an obstetrician-gynecologist could not serve as a woman's primary care physician.

Senators adopted an appeals process that applies to persons whose health insurance is provided through their employer. However, the bill stacks the process against the patient by letting the plan choose the reviewer. And, that provision would override the strong external appeals process enacted by the Texas Legislature in 1997 as part of the landmark patient protection legislation. On top of that, patients were not given the right to sue their health plans for negligent medical necessity decisions, which means health plans will have no accountability beyond the weak appeals process.

Possibly most damaging, the bill allows insurance plans, not physicians, to determine what is medically necessary. "I think that is the most devastating part of what came out of the Senate," Dr Baum said. "To pass a bill that says an insurance carrier or an HMO plan should be the entity to decide what is medically necessary is ludicrous. The two people who have to make that decision are the patient and the patient's physician."

Dr Baum says he is "disappointed" that Texas' two Republican senators voted for the Republican bill. "I'm not sure they fully understood the consequence of their vote," he said. "I think they had some concerns about allowing patients to have redress against their health carriers. And, I think they believe this review process that will be set up by the insurance carrier is going to be adequate, but we don't feel that way."

> "To pass a bill that says an insurance carrier or an HMO plan should be the entity to decide what is medically necessary is ludicrous. The two people who have to make that decision are the patient and the patient's physician."

In a recent letter to Gov George W. Bush, Dr Baum urged the governor to oppose the Senate bill and support a bipartisan approach to managed care reform. "We all agree that a strong, truly independent review system is the key to making the investor-driven HMOs provide the health care services for which our patients have paid. In Texas, it has been the key to keeping the vast majority of these disputes out of the courtroom.

"In very plain language," Dr Baum continued, "the Senate Republican version preempts Texas' independent appeal law and substitutes a substantially inferior appeal mechanism that is far from independent. Their version allows the health plan to handpick the reviewer, could drag out the review process for months, and is everything you expect in legislation drafted by the insurance lobby."

Meet the depressed

Some on Capitol Hill described the whole debate as a "very depressing week." Republicans closed ranks and voted down every Democratic amendment even though some of their members personally favored them. In some instances, the Republicans turned around and offered watered-down versions of virtually the same amendment. The lockstep votes were designed to avoid a party split like the one that embarrassed Republicans during the gun control debate earlier this year. And, despite denials by Republican senators, intense pressure was placed on them not to break ranks, observers say.

Democrats came in for their fair share of criticism, as well. Their insistence on running with provisions that even moderate Republicans argued would drive up health insurance premiums prevented a compromise proposal from being introduced. One observer says Democratic senators knew they had lost the day after the defeat of their first amendment to allow women to designate their obstetrician-gynecologists as their primary care doctors — one of the most politically popular provisions in their version of the Patients' Bill of Rights. After that, the remaining debate was little more than an attempt to establish a record that they could use against Republicans in the 2000 election campaigns, the observer says.

Since President Clinton has threatened to veto the Senate bill if it ever reaches his desk, the motive of senators from both parties may simply have been to build a campaign record.

Back to the House

What little hope that remains for enactment of substantive managed care reforms by Congress this year now rests with the House. Robert W. Sloane, Jr, MD, of Fort Worth, chair of TMA's Council on Legislation, says that three possible scenarios could play out there. First, speculation has been made that House majority leaders will put the Senate bill on a fast track, bypass the committee process, and take the Senate bill straight to the floor for a vote. The second scenario is that a bill similar to that passed by the Senate may advance through the House Education and the Workforce Committee. US Rep John Boehner (R-Ohio), chair of the Education and Workforce Subcommittee on Employer-Employee Relations, is attempting to move a bill that Dr

Sloane says is not likely to be much better than the Senate version.

The most promising scenario is that the House bill could originate in the House Commerce Committee, chaired by US Rep Thomas Bliley (R-Va). Several moderate Republican committee members — led by US Reps Charles Norwood, of Georgia, Tom Coburn, of Oklahoma, Greg Ganske, of Iowa, and others — have proposed a compromise plan called the Consensus Managed Care Improvement Act. Representative Norwood is a dentist and Representatives Coburn and Ganske are physicians.

The "consensus" bill includes the right of patients to choose their own doctors and hospitals. It creates a truly independent external appeals process and it gives patients the right to sue their health plans for negligent medical necessity decisions. Dr Sloane says the bill looks like something TMA and organized medicine can get "100% behind."

State Sen David Sibley (R-Waco), who authored the Texas patient protection laws, was in Washington, DC, shortly after the Senate debate to receive the American Medical Association's 1999 Dr Nathan Davis Award for his hard work on patients' rights in Texas. While there, he met with several of the Republican legislators who support the consensus bill to discuss the Texas experience and legislative strategy. Senator Sibley was quoted in the July 26 issue of *Newsweek* saying that patients' rights legislation deserves nonpartisan support.

"If you're going to hold a welfare mother accountable for a child out of wedlock, why not hold an HMO accountable for a medical decision it makes?" the senator told *Newsweek*.

John Stone, press secretary for Representative Norwood, says Representative Bliley has received the consensus bill, and Representative Bliley and US Rep John Dingell, of Michigan, the ranking Democrat on the Commerce Committee, are discussing whether they can produce a compromise.

Mr Stone says the consensus strategy calls for two bills to address the issues involved in the managed care reform debate. The Consensus Managed Care Improvement Act focuses on true patient protection issues, such as access to specialists and emergency room care, HMO accountability, gag rules, and continuity of care. A second bill — the Consensus Health Care Access and Choice Act — targets economic issues, such as insurance pools, tax deductibility of health care premiums, and medical savings accounts.

"One of the most divisive things in trying to reach a bipartisan solution in this whole debate is that there are a lot of solid, good business proposals out there that will lower the cost of health insurance, but the Democrats all hate them," Mr Stone said. "Likewise, we've got a bunch of great patient protections, and a large number of Republicans hate those. You try and put them both together in the same bill and suddenly nobody will vote for it."

By splitting the issues into two measures, chances of moving substantive patient protections to the House floor for a vote are increased, he says.

Representative Coburn also was optimistic the consensus bill would find support in the Commerce Committee. "We feel confident that the vast majority of the things in our bill will be in the bill that comes out of the Commerce Committee," he said. He adds that moderate Republican opposition to Representative Boehner's bill appears to have that measure bottled up in the Education and the Workforce Committee, improving the chances that the Commerce Committee bill will be the vehicle for House managed care reforms.

Predicting the future

Should GOP leaders attempt to fast track the Senate bill, moderate Republicans also will be able to block its passage on the House floor, Mr Stone says. "If that's the case, bring it on," he said. "The first amendment will be to substitute the consensus bill." He predicted the consensus bill could get as many as 300 votes in the 435-member House of Representatives if it is allowed to come to the floor.

Despite his optimism for the bill, Representative Coburn was not ready to count on that many votes. "The real question is this: do the Democrats really want to help patients or do they want to play politics? [Minority Leader] Dick Gephardt doesn't want to help patients. He wants to use it as a campaign issue. The Republicans walked right into that in the Senate and we're not going to walk into that in the House. We want a bill signed and we are willing to do what's necessary."

While Democrats' motives may be in doubt, so are those of the Republican leadership. Ms Barron says the outlook for enactment of adequate patient protections likely will depend on how large a role GOP leaders believe managed care reform will play in the next elections. Democrats campaigned heavily on the issue in 1998 and several Republican House members lost their jobs. Yet the leadership may not be convinced managed care was a key issue.

"If Republicans truly believe that the health care issue did not play a key role in the loss of seats in the last cycle, then they may not believe that it will play a role this time around," Dr Sloane said. "And, if it's not a big campaign issue, if they think they can shift the debate to other things, then they may choose to take their chances and not let it get to the floor." ★

"If you're going to hold a welfare mother accountable for a child out of wedlock, why not hold an HMO accountable for a medical decision it makes?"

The new disease team

Will Texas Tech's disease management test project begin a new turf war?

Artman

Delivering the best care to patients is a team effort, and as with any good team, physicians and pharmacists have always known their roles and have cooperated to achieve the best results. But in recent years, the boundaries separating those roles have blurred as pharmacists across the nation have begun efforts to take on more responsibility. Not all of their motivation lies in improving the quality of care, however, and some insist physicians should make the calls when it comes to revising the lineup. ➤➤

By Monica Maldonado, Associate editor

A case in point: The complications and prevalence of type 2 diabetes have always required a team effort, and yet in the fight against the disease, the team thus far has been overmatched. Somewhere among visits to physicians, registered nurses, certified diabetes educators, pharmacists, and dietitians, many diabetics fall off track, racking up medical bills that could otherwise be avoided. These patients contributed vastly to the $4 billion spent on diabetic patients in Texas in 1992. Studies estimate that medical expenditures for diabetics are almost four times higher on average than for nondiabetics.

It seems a worthwhile endeavor, then, to investigate whether the lineup should be reworked to create better outcomes, which in turn would lead to lower costs. In fact, a pilot project from the Texas Tech University Health Sciences Center School of Pharmacy, originally slated to begin this year, will try to prove that pharmacists should step up their involvement. But, so far, the proposal has met with delays, both from the Health Care Financing Administration (HCFA) and the Texas Medical Association. While both groups believe studying the value of increased involvement by pharmacists is worthwhile, they say the proposal needs further refinements, especially in terms of how physicians would fit into the program.

At press time, a six-member technical advisory panel of pharmacists and physicians, created by the Texas Health and Human Services Commission (HHSC) and including representatives from TMA, the Texas Academy of Family Physicians, the Texas Academy of Internal Medicine, Texas Tech, and the Texas Pharmacy Association (TPA), was discussing and reworking the proposal for Tech's "Care of Type 2 Diabetic Patients by Community Pharmacists: A Texas Medicaid Demonstration Project." So far, about the only thing the group seems to have settled on is that the name be changed to "A Physician/Pharmacist-Team Approach to Care of Type 2 Diabetic Patients: A Texas Medicaid Demonstration Project." It's a mouthful, but it signals that physicians have made inroads in gaining control of the project.

Jill Aslakson, TMA's scientific affairs specialist who has been organizing the critique of the proposal, says that from physicians' viewpoint, the issue is twofold: What is the cost benefit of pharmacists' expanding their role in the treatment of diabetics under the supervision of physicians, and is this study designed well enough to answer that question?

An idea raises eyebrows

The idea of pharmacists applying disease management to care for patients with chronic diseases is not new. A story in a January 1999 *Wall Street Journal* titled, "Pharmacists Are Starting to Move in on Doctors' Turf," reported that 21 states (including Texas) have given pharmacists the authority to initiate or modify drug treatment if they have collaborative agreements with physicians. Last April, HCFA made Mississippi the first state to reimburse pharmacists under Medicaid for advising patients with diabetes and other chronic problems, but private insurers are cool on the idea, the paper reported.

Responding to questions from *Texas Medicine,* Arthur Nelson, RPh, PhD, dean of the Texas Tech pharmacy school and principal investigator for the proposal, said he believes pharmacists "can help fill the gap to render quality patient care at lower system costs.

"It's not economical for the physician to provide these services and interventions," Dr Nelson said, "especially in a managed care system in which physicians don't receive adequate compensation for chronic disease management."

And according to Dr Nelson, other compelling economic reasons to expand the role of pharmacists exist. Not only would it reduce system-wide expenditures, but it also could positively affect pharmacists' income.

"Managed care has put pressure on pharmacists' professional dispensing fees," he said. "Developing these types of direct patient care services is vital for the long-term economic viability of the profession."

Physicians who have followed the history of the disease management concept — in which teams of physicians and other health care professionals work together to design a treatment plan for patients with chronic diseases in an effort to improve patient compliance with treatment guidelines and reduce costs — have heard this line of reasoning before. Having healthier patients is indeed one reward, but the driver for the recent growth of disease management is apparent: the $500-billion gold mine that is the business of chronic disease care.

"It's not economical for the physician to provide these services and interventions, especially in a managed care system in which physicians don't receive adequate compensation for chronic disease management."

According to the recently formed Disease Management Purchasing Consortium and Advisory Council (its very existence testifying to the growth of these programs), disease management is already a $350-million-a-year industry. In fact, the idea was the brainchild of pharmaceutical companies intent on marketing their products to the right patients. Now, private vendors offer their services to health maintenance organizations and other insurers, bidding to bring down their expenditures on chronic disease care.

But Al Lewis, founder of the consortium, argues that it's impossible for a disease management program to save or make money without improving the quality of care: "You can't have one without the other." He also reports that while the industry is growing, a lack of resources, which can sometimes mean a lack of supporting physicians, can hold a program back.

Beverly Koops, MD, medical director of the Texas Department of Health's health care financing arm, agrees: "In a sense, what might turn physicians off is the fact that some of them went to school

for 10 years to do just that — manage disease. But really, disease management is just a way to organize the team, with doctors as the captains, of course."

Staking their claim

HCFA received a copy of the Texas Tech proposal in December 1997, and this April it returned an initial critique to Linda Wertz, the state Medicaid director for HHSC. That critique contained several questions for Texas Tech and suggested the school make further refinements before HCFA could perform a more technical review. One question concerned the reaction to the proposal from the physician community. At that point, TMA was busy preparing its own critique of the same proposal.

TMA became aware of the proposal just a month before HCFA did and a year after Tech had constructed it. Shocked that Tech had proposed such a large-scale study without the early involvement of TMA, the association immediately forwarded the proposal to the TMA/TPA liaison committee for critique. It then distributed the proposal to about 15 endocrinologists, diabetologists, and family physicians who work with diabetics. The resulting critique, which included each of the physicians' comments, was passed on to HHSC Commissioner Don Gilbert in April.

TMA physicians agreed that in terms of making sure patients comply with medication schedules, the proposed study could show improved outcomes. "But a major concern is that it goes beyond the drug-related aspects of the disease," the critique stated. The physicians took issue with the suggestion that pharmacists would perform what the proposal called "physical examinations," including collecting and interpreting laboratory data, and analyzing patients' cardiac risk factors. Critics wonder if pharmacists have the appropriate training and knowledge for such tasks. Texas Tech's proposal says the project is specifically designed to examine "how patient outcomes differ for patients receiving *primary care* from pharmacists/caregivers collaborating with physicians."

Patrick Pevoto, MD, an Austin obstetrician-gynecologist who cochairs the liaison committee and who is a licensed pharmacist in Texas, said in his critique that some of the tasks proposed to be performed by pharmacists are "too closely related to the practice of medicine. I realize there will be basic training in these areas for pharmacists," he wrote, "but I don't believe it can, in any way, substitute for the clinical training obtained in 4 years of medical school."

"I think the proposed plan is beyond the capabilities of a certified diabetes educator and/or pharmacist, and may put the patient at risk."

Though the proposal says that pharmacists will be trained to perform these complicated assessments, TMA physicians argued that the amount of training would not suffice. "I think the proposed plan is beyond the capabilities of a certified diabetes educator and/or pharmacist, and may put the patient at risk," Fred Ciarochi, MD, an endocrinologist in Duncanville, wrote in his critique.

Dr Nelson, dean of the pharmacy school, responded, "Not all practicing pharmacists are prepared to enhance their roles beyond traditional dispensing responsibilities. However, more recent pharmacy graduates, especially PharmD graduates and others who have participated in professional development beyond pharmacy school, are capable and motivated to develop the knowledge and skills to meet patient care needs safely and effectively." Furthermore, he said, "Only pharmacists who have demonstrated appropriate knowledge and skills through an assessment process conducted by pharmacists, certified diabetes instructors, and physicians will be allowed to participate in the study."

Dr Nelson also pointed out that the proposal "clearly provides that no patient will be entered into the pharmacist care services without the expressed permission of the patient's attending physician." He says the pharmacist and physician will be required to develop written protocols that would define the scope of services the pharmacist may render.

But TMA's critique argues that the proposal only vaguely addresses the pharmacist-physician relationship, an issue it says could lead to problems down the road, such as the possibility that a patient could receive conflicting information or that a physician could be held liable for physical assessments and treatment decisions made by the pharmacist. Many of TMA's criticisms are based on concern over the need for appropriate medical management. In fact, the proposal would allow pharmacists to contact patients to participate in the program and choose physicians based on their willingness to comply.

And yet, the proposal says pharmacists would comply with the Texas Pharmacy Act and the Medical Practice Act, both of which establish that a pharmacist may provide drug therapy management only under written protocol from a physician. The Texas State Board of Medical Examiners also has written rules pertaining to "drug therapy management" that put physicians at the helm. Inevitably, the project design and protocols would have to comply with these laws, and TMA predicts HCFA will require Tech to clarify the role of physicians in its proposal.

At the most recent negotiation meeting, the six-member panel discussed the services pharmacists would be providing and agreed that the proposal should say in more detail that the pharmacists would operate under physician protocol. The panel also reworked the language of the "physical examination" aspect of the proposal to rein in some of what the pharmacists will be able to do. But the panel has only begun addressing the issues in detail.

Negotiating research design

In addition to the need for defining physicians' roles in the diabetes pilot project, some doctors believe the proposed design has critical research flaws, beginning with the purpose of the project, which is to "demonstrate the effects of having the pharmacists participate in the disease management of Medicaid diabetic patients."

In his critique of the proposal, Joe Cunningham, MD, an internal medicine specialist in Waco, wrote that although he believes patients would benefit from more time and attention, certified diabetes educators and diabetes programs exist that are already trying to address this need. "Having the need tackled by pharmacists might dilute these programs, and visits to the doctor's office might be decreased to the point that comprehensive medical care would be lessened." Responding to this concern, Dr Nelson pointed out that with fewer than 700 certified diabetes educators in Texas to treat about 850,000 diagnosed diabetics, it makes sense to recruit other professionals who can improve diabetics' care.

Texas Tech's proposal resulted from 1997 legislation that would allow the creation of a pilot program to test pharmacists' role in diabetic care and perhaps fill in those aspects of diabetic care that are missing. The program, in which pharmacists would be allowed to participate, would waive the three-medication maximum imposed on Medicaid managed care patients so they would have access to the same benefits as fee-for-service Medicaid patients. That legislation led to a request from the Texas Pharmacy Association for Tech to develop a pilot program.

But the history of that legislation is mired in compromise. In the 1995 session of the legislature, a rider attached to an appropriations bill for the Texas Department of Health required that expenses Medicaid pays to pharmacists be reduced by 4%, in light of the fact that expenditures for prescription drugs consume 7% of Medicaid spending in Texas. Reacting to the change, the pharmacy association — along with Rep Dianne White Delisi (R-Temple) and then-Health

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and Human Services Commissioner Mike McKinney, MD — developed the 1997 legislation for a pilot program.

In analyzing the proposal, however, TMA physicians found that even within the proposal's narrow intention — "to demonstrate the effects of pharmacists' participation" — the study's scope may not allow for useful outcomes. The proposal suggests measuring results after just 2 years, which physicians believe may not be long enough. Dr Cunningham wrote, "It has taken us many years to get even a very small handle on the effects of various therapies for the type 2 diabetic. Any short-term study could give no information, or worse, erroneous information regarding benefit." Even HCFA doubted that observing just 1,000 patients over 2 years would generate significant outcomes. The six-member panel has since agreed to expand the project to 5 years.

The proposal also suggests using two control groups to compare and measure the effects of the treatment on the patients in the experimental group, but physicians worry that the difference among the control and the experimental groups may disqualify any comparisons. In addition, the physicians say the proposal's suggestion to keep both patients and physicians from knowing which group they are in would be impossible to maintain, thereby diluting the effect of a control group. Physicians also found that without standardized protocols for each pharmacist and physician, comparing the outcomes for each patient would be useless.

"Each of the physicians we asked to review this proposal came up with virtually the same concerns," said Ms Aslakson. "That is a red flag to us that we really need to work with Texas Tech to create a proposal that would enhance physicians' care of diabetics yet wouldn't alienate physicians who would otherwise be eager to participate in the project."

Dean Nelson has agreed to cooperate with TMA but wants to limit the discussion to scope-of-practice and credentialing issues for pharmacists. He has said he does not believe any of the six panel members are qualified to critique research issues.

Open to possibilities

One physician who critiqued the proposal reported positively on his experience in working with pharmacists to care for type 2 diabetics. Keith Cryar, MD, an endocrinologist working at Scott & White Clinic, already relies on pharmacists and their ability to help implement treatment plans for his patients. His program enlists doctors of pharmacy, nurses, dietitians, and educators who work together based on a protocol written by the physician. In this program, the pharmacist makes sure the team completes each item on the patient's checklist every time the patient comes in, ensuring that the key monitoring and screening studies are not neglected. After a year, Dr Cryar says, his patients' glycosylated hemoglobin levels have dropped, but he admits it is too soon to measure the program's success.

"I have a good relationship with the pharmacists in this program," said Dr Cryar, which he says is the key to making a diabetes program work. "We all know what our roles are, and we sometimes cross traditional boundaries in trying to offer what each of us can best do to help the patient succeed." Noting that there is a growing body of research based on pharmacists' role in diabetes care, Dr Cryar added, "Pharmacists have some useful skills to bring to the table."

TMA members say they recognize this, too, adding that the scale and intention of Tech's proposal is important and admirable. But they caution that regardless of whether physicians get involved now, pharmacists' involvement in patient care might happen without them.

"I admit we weren't very receptive to this idea in the beginning," says Dr Pevoto, cochair of the TMA/TPA liaison committee, "but this is a new paradigm in the care of patients with chronic disease, some of whom have access problems. We are fortunate to have the opportunity to work with pharmacy in trying to shape these programs and improve the health care of our patients instead of watching the program evolve without the input of medicine." ★

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WOMEN in MEDICINE

They've made progress, but THE STRUGGLE CONTINUES

By Melissa McEver When Janice Knebl, DO, was in medical school, a male classmate shared this revelation with her after they went through several rotations together: "I never realized you wanted to be a doctor as much as I did. I thought the women in our class came here to find husbands."

Dr Knebl, now chief of geriatrics at the University of North Texas Health Science Center at Fort Worth, can laugh at that comment today. "Can you believe that? It's only in hindsight that I see just how outrageous that was. And that was in the late '70s — not that long ago."

What a difference two decades can make. Since then, women physicians not only have silenced naysayers who thought they didn't take medicine seriously, but they also have made their presence felt by joining the profession in large numbers and by rising to higher levels of visibility in the practice of medicine. They also are assuming leadership positions in organized medicine, and a Texan recently completed her term as the first woman president of the American Medical Association.

The numbers tell it all: 300% more women physicians are practicing now than in 1970, and women soon will represent a third of US physicians. According to the latest available figures, the number of women graduating from medical schools across the country has jumped from 700 during the 1969–1970 school year to 6,614 in 1996–1997. That same school year, women accounted for more than 42% of total medical school enrollment, and the number is expected to continue rising.

Also, judging from the numbers of female residents in certain specialties, it may not be too long until the majority of pediatricians and obstetrician-gynecologists are women, and until women comprise nearly half of several other specialties, including family practice, psychiatry, and dermatology.

On top of that, many women physicians are maintaining their practices while striving for balance in their work, family, and organized medicine roles.

Truly, women physicians have many successes to celebrate. However, for all the obstacles women have overcome, other statistics reveal a lingering problem: a significant disparity between the number of men and women claiming certain leadership roles in academia and administration. Apparently, the struggle isn't over.

Currently, of the total US medical school faculty, 31% of the men faculty members are full professors, but only 9% of the women faculty have achieved that position. The percentages are even smaller in administrative positions. Only eight women serve as medical school deans in the United States; none are in Texas. And though the number of female associate deans and assistant deans has increased dramatically since the 1970s, most women physicians insist that the number of women deans still does not reflect the physician population.

Recent figures also suggest that women are not being represented adequately in physician executive and medical director positions in hospitals and health care systems. Of the 12,500 members of the American College of Physician Executives (ACPE), which includes a variety of positions from medical directors to administrative roles, only 1,370 are women. Though not all physician executives are members of ACPE, this disparity in membership likely is reflective of the current trend, says Patty Reynolds, ACPE director of information services.

And in a 1997 survey by the AMA, of the 13,467 physicians who reported themselves to be in administrative positions, only 2,418 were women.

After all the strides women have made, what is causing these disparities to remain? Some say women need time to move up through the ranks of academia and administration — after all, more than 67% of female physicians are under age 44. Of those, 30% are younger than 35.

"Now that there are increased numbers of women coming into a time of their lives when they would be reasonable candidates for leadership positions, we need to wait and see," said Joan Richardson, MD, professor of pediatrics at The University of Texas Medical Branch (UTMB) at Galveston. "If it still doesn't happen, then I think we can say, 'Hey, we've got a problem here.'"

Some physicians have chosen to opt out of some of these positions, deciding instead to take career paths that will allow them to spend more time with their families. "I think it's kind of sad, at least in my mind, that I had to sacrifice an academic career to be able to raise my kids, be active in organized medicine, and have my sanity left," said Susan Rudd Wynn, MD, a Fort Worth allergy and immunology specialist, vice speaker of the Texas Medical Association House of Delegates, and a member of the Texas A&M University System Board of Regents.

Whatever route women physicians have chosen in their careers, the important thing, many of them say, is that when it comes to choosing a path, a woman should do what she loves, knowing that even if few other women have accomplished her goal, it can be done. "I love my work. I really enjoy my activities with organized medicine. I love associating with the physicians and staff, and I love my kids," said Diana Fite, MD, a Waller emergency medicine specialist who works in Houston. Dr Fite maintains a 60- to 70-hour workweek in a hospital emergency department, is active in TMA and her specialty society, and is raising eight children. "You can do *whatever* it is you want to do."

It's all academic

Many women love teaching and research, and want that to be the heart of their medical careers. One is Margaret Pearle, MD, a urological surgeon and assistant professor in the Department of Urology and Mineral Metabolism at The University of Texas Southwestern Medical School at Dallas.

"I love practicing medicine, but research, being on the cutting edge of what's new in my subspecialty — that's what drives me. That's what is fun to me," Dr Pearle said.

The obstacles facing women in academia can make that goal difficult to reach. Some physicians point to the rigidity of the tenure track as a real hurdle for women who want both an academic life and a family. Medical schools usually require faculty members seeking tenure to work full time as well as meet other requirements, including extensive re-

"I think it's kind of sad, at least in my mind, that I had to sacrifice an academic career to be able to raise my kids, be active in organized medicine, and have my sanity left."

search efforts. And the tenure track often has a time limit. For instance, at Texas Tech University Health Sciences Center School of Medicine, the limit is 7 years for an assistant professor and 4 years for an associate professor, both of which could prove difficult for a working mother with multiple time demands.

Such a structure could be a reason why fewer women have achieved the rank of full professor or received tenure, physicians speculate.

"For some women, that lack of flexibility is a real source of problems," said Dr Richardson, who is a full professor. Because she has no children, the flexibility issue hasn't affected her as much, she says, adding that not having children has made it easier for her to work the needed hours and fulfill research requirements.

Some medical schools do provide some options for women who wish to work part time. At Texas Tech, new faculty members can opt not to go through the tenure track if they wish to work part time and then later begin the tenure track when they're prepared to work full time, says Rial Rolfe, PhD, assistant dean for faculty development.

However, when a physician faculty member opts not to be on the tenure track at Texas Tech, none of the time served in the position counts toward tenure. So faculty members working part time often end up far behind those on the tenure track.

Dr Rolfe says the full-time requirement to achieve tenure is necessary because of the importance of a tenured position. "It's a lifelong contract with the state of Texas," he said. "And because of that, schools want to have an individual giving 100%."

Dr Pearle also has no children, and she says it would be very challenging for her to give 100% with a family to care for, too. "But it's not impossible — women do it all the time," she said.

But the multiple responsibilities often leave women feeling torn. "It becomes a very difficult push-pull kind of situation," said Kathleen Williams, MD, associate dean for student affairs and admissions for Texas A&M Health Science Center College of Medicine.

Dr Williams, who has two children, says that working as a dean also can present obstacles to women with children.

Theresa DiMenno

Diana Fite, MD, takes a few minutes to relax with her husband, Ron Patton, and eight children at their home in Waller. She says women physicians must remember it is possible to accomplish many goals if they really want to.

Diana Fite, MD, helps patient Jimmy Rochester sit up as another busy day unfolds in the emergency room. She works 10 to 12 hours a day and still manages to find time for her family and organized medicine responsibilities.

"I'm a physician first, a woman physician second."

AMA's first president reflects on her term

In a year of fighting for antitrust reform for physicians and the Patients' Bill of Rights, gender couldn't be called the biggest issue of the presidency of Nancy W. Dickey, MD, immediate past president of the American Medical Association. "It hasn't been a major issue," said Dr Dickey, a College Station family physician. "There has been a huge number of other issues to address."

Dr Dickey completed her year as AMA's first woman president in June, and looking back on the year, she says her ground-breaking presidency wasn't focused so much on women physicians' issues as on issues affecting all physicians. Being the first woman president, though, opened some doors that otherwise would have been closed. "My being a woman opened doors to some media and to some meetings," she said. "People were willing to talk about these defining issues because I was a somewhat different AMA president."

These defining issues included planning for long-term reform of the US health care system, as well as bills seeking to allow physicians to collectively bargain with managed care plans, initiatives to protect medical records privacy, and end-of-life care education.

But, of course, Dr Dickey didn't leave her gender at the door — issues affecting women certainly were of concern to her. "There's still data that suggest that women face tougher battles in academic positions and in senior management roles," she said. "These numbers should be watched carefully. And pay discrimination continues to be an issue as well. If you're looking per-patient, per-hour of work, women still are paid measurably less for the same work done."

She thinks the AMA's role in addressing these problems should be to conduct further research and then develop programs that could help, such as the AMA Women Physicians Congress, recently formed to give women physicians' concerns a special voice.

But Dr Dickey says her primary goal as president was addressing issues that impact the careers of every physician, male or female. "At least in terms of the AMA, I consider myself a physician first and a woman physician second," she said. And when it came to issues of physician representation and patient care, Dr Dickey found that all physicians are working toward the same goals.

Jim Lincoln

"When we sat down to tackle issues or walked out to meet the press, we were physicians. Whether we were black or white or brown, male or female, young or old, we were physicians," she said. "And one of the beauties of being a physician today is the diversity that physicians bring. That adds some spice and a multitude of different perspectives at times."

As for the legacy her presidency will leave and its impact on other women physicians, Dr Dickey leaves that for the history books to decide. "I certainly gave it 110% effort and as much commitment as anyone could give," she said. "But it's not the legacy of a person that counts, rather it's the legacy of an organization."

She hopes other women physicians will take inspiration from her presidency. "Other women who aspire to leadership may take some small piece of things I did and put them together to make their very own quilt of solutions," Dr Dickey said. And she hopes her experiences will show other women that they can assume successfully such leadership roles. "It can be done. I assure you that many others are far more talented and energetic than I am, so if I can do it, certainly it can be done by others."

> "Having a family would not preclude somebody from doing this job well, if she wanted to do a good job. Not having a family wouldn't guarantee that someone would do well, either."

Because her children are older, she says, she can be more flexible with her hours and therefore receive less criticism from coworkers. Other women who work part time in academia because of family commitments face discrimination, she says. "There's a general attitude that you're not serious about your career."

Women at the helm

The ratio of men to women in leadership and administrative positions in hospitals is another problem the medical profession needs to address, says Ms Reynolds. "It's one of the biggest problems we face," she said. "How can women break into the administrative ranks?"

Dr Richardson, who also is medical director of UTMB's hospital, believes the problem will correct itself as more women enter medicine. "I think as the number proportionately increases — and that's going to happen — you're really going to see a large number of women who are chairs of departments and chief operating officers of hospitals. I think we'll begin to see that soon," she said.

It is possible that just as with academia, the time pressures involved in a leadership position could steer some women with families away, Dr Richardson adds. "There are just so many issues for which I'm responsible," she said. "And I have a pretty tight schedule." But those time constraints can be difficult for men or women, and because a woman has a family doesn't mean she can't devote the needed time, she says. "Having a family would not preclude somebody from doing this job well, if she wanted to do a good job. Not having a family wouldn't guarantee that someone would do well, either," Dr Richardson said.

Dr Wynn, who is raising two children as a single mother while working in private practice and serving in numerous leadership roles in organized medicine, says the rigidity of some positions and of the academic environment would not have given her the time she wished to spend with her children. "I sacrificed some of the things I would have liked to do. I knew those would not give me the flexibility and independence I needed to achieve my goals," she said. "Working 50 to 60 hours a week with small children — that's not how I wanted to raise my kids."

Many other women physicians feel compelled to make such choices because "women often feel they have to choose between career and family, and that's really counterproductive for our society," she said. "In general, our society needs to do a better job of helping both parents balance child-raising and career."

Mentors make the difference

Many physicians think a lack of female mentors and role models also may keep some women physicians from pursuing certain career paths. This is especially a problem for the growing number of women in medical school, says Dr Knebl. "It's a shame, because we need more role models for all these female students now."

Such role models can provide invaluable guidance for students making decisions about their careers, says Dr Pearle. Supportive female friends and mentors helped her choose urology, a specialty in which there are few women, she says. "Two female friends of mine were in urology, so it never seemed like such an unusual career choice," she said. "You see these physicians, you see their lifestyles and their philosophy of practicing medicine. If that strikes you as something that you want to emulate, then I think you're attracted to that specialty," when otherwise you may overlook it, she said.

Unfortunately, in fields in which women are poorly represented, few mentors are available for women.

As one solution, many women physicians are making an extra effort to reach out to younger women. Dr Richardson, who says she was helped by both men and women mentors, takes any opportunity to mentor other women physicians and gives pep talks to children interested in medicine. She also urges young women to seek guidance from male mentors as well as from female mentors. "Reach out to senior people who you feel can teach you things."

Also important are guidance and encouragement, says Dr Pearle. "I've been extremely fortunate to have a supportive chairman and colleagues," she said. "If you surround yourself with the right people, you can do anything."

"You really have to avoid the superwoman syndrome. You just have to be very careful about choosing what will make you happiest."

The juggling act

For some women physicians, the best choice is to work less while raising a family. Others work extra hard to set priorities and get organized while maintaining schedules some might deem impossible. Driven by the sheer will to succeed, however, the impossible becomes attainable for them.

Dr Wynn decided to work part time after her residency, when she had small children. "Part time for a doctor, anyway," she laughed. Now, she works about 30 hours a week so she can spend time with her kids in the evenings.

She also strives to maintain balance in caring for herself so she has more to give to her children and to her patients, she says. "You can't let yourself not be in the equation," she said. And as for the stress involved in juggling her responsibilities, Dr Wynn said, "These are things I love. Just because you're juggling lots of things and it's stressful doesn't mean they're always in conflict. And I'm choosing to do all these things," she said.

Dr Fite chooses to do more probably than most people could handle. Working 10 to 12 hours a day in emergency medicine, Dr Fite also holds several positions at TMA, her county medical society, and her specialty society. And then there are her eight children, aged 4 to 20.

Dr Fite says her husband, who currently stays home with their children, deserves the credit for her ability to do what she does. "It's been hard for everyone at times because work does take up so much of my time, but my children are essentially what I work for. They're definitely my pride and joy," she said.

Her schedule allows 4 hours of sleep in the midst of a long workday, time with her children, and her organized medicine duties. Until recently, she also maintained a part-time outpatient gynecology practice.

Stressful? Perhaps, but Dr Fite thrives on handling multiple responsibilities, and she urges women physicians to believe that accomplishing many goals is possible if that's what they want to do. "You can have all the children you want, if that is what you want," she said. "You can make the time to do what needs to be done, and the return you get back in the joy of the children is far worth any toil or stress."

Dr Williams, a single mother, has learned that the secret to juggling priorities is to have realistic expectations. "You have to avoid the superwoman syndrome," she said. "At one time, I was killing myself trying to do everything for everybody. It wasn't necessary. You just have to be very careful about choosing what will make you happiest. You have to be creative," she said.

Taking the lead

Doing what you love and going after what you want are surefire ways to overcome obstacles that may hinder a successful career, say these women physicians. Another way to overcome the obstacles imposed by the powers-that-be is to become a power yourself, rather than shrink from the situation, says Dr Knebl, who is considering becoming a medical school dean.

"You can change things better as an insider than as an outsider," Dr Knebl said. "If you want to change the rules, you've got to be making them. If a medical school is going to begin being sensitive to these issues, we've got to have women at the helm."

That seems like a catch-22 — more women are needed at the helm so they can allow women to be at the helm.

Someone must take that first step toward leadership, if that's what the woman physician wants, she says. "I always thought, when I get in there I'll make a change. And I'm sticking to what I want to do," she said.

Once a woman takes that initiative, the impact can be far-reaching. Just ask Dixie Melillo, MD, a Pasadena surgeon who, because of her efforts to serve low-income women by opening a breast cancer screening clinic, recently was inducted into the Texas Women's Hall of Fame. Her nonprofit organization, The Rose, has helped provide services to nearly 9,000 uninsured women — all because Dr Melillo saw a flaw in the system and wanted to make a change.

"There's a real problem in the health care system today. The needs of working women with no insurance aren't being addressed. And in the hospital administration, you have to do what the hierarchy says," Dr Melillo said.

And that wasn't acceptable to her. By opening the clinic, Dr Melillo already has made a difference in the community. "Practicing medicine is such an honor and a gift," she said, adding that sharing that gift brings her great fulfillment.

Of the many paths women physicians choose to take and the many hurdles left to clear, their insight all converges on one point: the challenges are part and parcel of the career, and overcoming them can be part of the joy of the profession.

Dr Knebl summed it up best: "I figure another way around obstacles. And I ask for forgiveness rather than permission. I enjoy the challenge — I think if it were easy, I wouldn't want to do it." ★

Melissa McEver is an Austin writer.

Dr Sofie

Frontier surgeon blazed a trail for other women to follow

By Mike Cox

Randolph and Elfriede Prell lived in a modest frame house on a quiet street in Brazoria, not far from the Brazos River. But one day, the tranquility of the neighborhood dissolved faster than a powdered nostrum in a cup of hot water, when a man with red spots all over his face shot out of the front door.

Startled residents and passersby heard raised voices — one male, the other female — coming from the house. A heated argument, one that seemed to involve the man running down the street, was in progress. When one person yelled, the other shouted back even louder.

The confrontation inside was between Randolph Prell and his mother-in-law, Sofie Herzog, MD. Vigorously shaking his finger, he remonstrated with her for allowing a smallpox patient in his home. The doctor, wagging her finger right back, told Mr Prell that how she handled her patients was her business, not his. And how dare he chase the poor man out of the house? He needed treatment, not trauma.

The shouting grew so loud, as was later related, "that dishes rattled on the kitchen shelves."

The argument ran its course, and so, presumably, did the patient's disease. Mr Prell and his mother-in-law eventually resumed speaking to each other, but the incident convinced the doctor it was time to relocate her office. She began construction of her own house. Two rooms would be for her medical practice; the other would serve as her residence.

The story of the doctor's noisy set-to with her son-in-law did nothing to detract from her local image as an eccentric. Not only was she the first female physician in Brazoria County, she was the first woman surgeon in Texas.

Archives Division - Texas State Library

Born in Vienna, Austria, on February 4, 1846, Sofie Dalia was the daughter of a doctor. When she was 14 or 15 — accounts vary — she married Dr August Herzog. Like her father, Dr Herzog was a respected Vienna physician. The couple had 15 children, including three sets of twins, but eight of those children died as infants.

In 1886, the family moved to New York, where Dr Herzog took a staff position at the US Naval Hospital. With her children grown, Sofie decided that she, too, wanted to practice medicine. She went back to Vienna, where she earned a medical degree from the University of Graz. Returning to the United States, she undertook additional medical instruction in New York, then opened a practice in Hoboken, NJ.

The couple's youngest daughter, Elfriede Marie, was teaching school in Philadelphia when she met Randolph Prell, a merchant visiting from Texas. They married on January 24, 1894, and Mr Prell and his bride returned to Texas. When their first child was on the way a year later, the couple took the train to New Jersey so Elfriede's physician-mother could handle the delivery.

Gone to Texas

Soon after that new life began, August Herzog died. Suddenly a widow and with her children scattered, Sofie decided to join her daughter in Texas. As one contemporary newspaper article reported, she believed "that a wider field for her endeavors existed" in the Lone Star State. Too, she could dote over her new grandchild. The doctor lived with Elfriede and Randolph in Brazoria until the dustup over the smallpox patient.

Dr Herzog's arrival in the small coastal community created quite a stir. She was not the first woman physician in

Texas (that distinction is believed to belong to Dr Margaret Ellen Holland, who began a practice in Houston in 1871), but when she came to Texas in 1895, she was a pioneer in a field dominated by men. Queen Victoria reigned in England and so did the prim and proper mindset of an age that came to be called "Victorian" in her honor.

"A beautiful woman who talked familiarly about all parts of the human anatomy was as great a curiosity to the natives as they were to her, and she immediately became the chief topic of conversation," one writer later said of the doctor.

The fact that she wore her hair cropped short and rode a horse like a man, disdaining a sidesaddle, was the talk of the town. But she had two things going for her: she was good at what she did, having been trained in the city that was then the world center of medicine, and she was one of the few doctors in the area. When someone had a broken bone that needed setting or a baby about to be born, most folks were not too picky about the gender of their doctor. Soon the people of Brazoria County were calling her simply "Doctor Sofie."

The occupant of the house loaned the driver a doubletree. By 5:30 am, the patient had been treated and the exhausted, muddy doctor was finally back home.

Her driver, the article concluded, had "lost all his apostolic religion and swears he'll never drive the doctor again. The doctor swears the same thing."

Joining the Texas Medical Association early on, Dr Sofie seldom missed a meeting. She was a frequent speaker and won several honors.

Railroad doctor

Eight years after Dr Sofie moved to Texas, a developer named Uriah Lott founded the St Louis, Brownsville & Mexican (SLB&M) Railway. Mr Lott never achieved his goal of connecting St Louis to Mexico's Yucatan Peninsula, but his line brought the first rail service to much of South Texas, stretching from Brownsville to Houston via Brazoria County.

As construction began on the section between Robstown and Bay City and on toward Houston, Dr Sofie's business picked up. Construction accidents were common.

"A beautiful woman who talked familiarly about all parts of the human anatomy was as great a curiosity to the natives as they were to her, and she immediately became the chief topic of conversation."

One rainy Sunday night, Dr Sofie learned firsthand that smoking can be dangerous to a person's health. She had been called to the small town of Hawkinsville to see a patient. Eight miles from Brazoria, as the doctor graciously held the reins of the buggy so her driver could roll a cigarette, a wheel went off the bridge they were crossing. The horses lunged, hurling the driver into a slough. Worse, the horse broke the doubletree, the crossbar that connects the horses to the wagon.

When the driver climbed out of the water, Dr Sofie suggested that he cut a piece of wood and improvise a replacement. The driver asserted, as a local newspaper reported soon after, that he was no "buggy doctor." His recommendation was that they ride the two horses to a nearby farmhouse for help.

The doctor, however, did not feel she was dressed for such a ride and refused.

"They finally started walking for a . . . house two miles away," the newspaper article said. "The doctor was in front, carrying a lantern and her heavy satchel of instruments. [The driver] followed, packing a heavy grip and leading the horses. The doctor lost one shoe and then the other, but on they went until the light of the cabin was seen."

So were shooting and stabbing scrapes involving the tracklayers. Word of her medical skills and pleasing bedside manner spread up and down the line.

She made calls in her buggy, or, if roads were too muddy for her wagon, she traveled astride a horse. Often, she rode on handcars, boxcars, or train engines to reach someone along the line who needed the services of a doctor.

In 1906 or early 1907, the railroad formalized its relationship with the doctor, appointing her chief surgeon of the SLB& M. She got the job over several male surgeons. When word reached the railroad's headquarters that a female surgeon had been hired by a division official, Dr Sofie received a polite, carefully worded letter asking her to relinquish the position.

"I'll keep this job so long as I give satisfaction," she is said to have replied to the railroad management. "If I fail, then you can free me."

Though Dr Sofie was a woman in what most people of her time considered a man's job, she never gave the railroad cause to fire her. She frequently stressed that she "wanted no odds" because she was a woman. She remained on the line's payroll for the rest of her life.

The necklace

Even if the railroad had fired her, the SLB&M was far from her sole source of income. She continued her thriving private practice and dabbled in real estate. Over the years, beginning in 1907, she purchased numerous lots in Brazoria. In association with a Houston land development company, Dr Sofie had a two-and-a-half story frame hotel built across the street from her home and office. The Southern Hotel became the town's social center.

At a crowded affair marking the hotel's grand opening, the disgruntled wife of a former railway employee, believing Dr Sofie had somehow cost her husband his job, fired a shotgun blast at the doctor. The load of lead ripped a ragged hole in a screen door, narrowly missing the doctor. Dr Sofie laughed off the incident, and the party went on.

It wasn't that the doctor didn't know what a firearm could do to a human body. She had become particularly adept at removing bullets from gunshot victims. She presented a paper at a meeting of the South Texas Medical Association on one of her techniques: elevating a gunshot patient to such an extent that gravity could help her get the lead out, so to speak.

Only twice in her career was she unsuccessful in recovering a bullet. When she had accumulated more than a score of extracted pieces of lead — each representing a successful procedure — she had a jeweler fashion her a necklace with a gold bead threaded between each slug. She wore it as a good luck piece for the rest of her life. No matter whether it worked for her, it certainly represented luck on the part of 24 patients.

Dr Sofie collected more than bullets. She had a world-class collection of carved walking sticks. Another of her collecting interests was stuffed animals, birds, and snakes. She did her taxidermy work herself, skinning rattlesnakes and nailing their hides to the side of her carriage house to dry. Shelves in her office were laden with jars of malformed fetuses and full-term babies with deformities, including one with two heads and three arms. Though preserving the results of genetics gone awry did have a certain scientific value, she also used the specimens to convince women to take better care of themselves during their pregnancies.

Balancing career and family

Judging from accounts at the time, Dr Sofie's investment in her profession was exceeded only by the joy she found in her children and grandchildren. "Few professional women," one newspaper said of her, "have succeeded in better combining the duties of home and career. Some of her friends, indeed, felt that the doctor manifested two widely divergent personalities. In her family life [and] social relations she was feminine to the finger tips, for all the fact that she wore her hair short and sometimes affected a rather mannish hat."

After a long ride to treat a patient, she often unwound when she came home by taking up her crocheting.

When she was 65, the doctor married Marion Huntington, a 70-year-old widower. When she and her husband signed their marriage license, she scratched out the terms "Miss" and "Mrs" on the form and wrote in "Dr." After the August 21, 1913, wedding, she moved to Mr Huntington's plantation 7 miles outside Brazoria. Despite her strong sense of self-identity, she did use her husband's last name.

> "Brazoria, and indeed a large part of South Texas, loved and honored the woman physician who had ministered to so many people for more than a quarter of a century...her death has given thousands a sense of deep personal loss."

Though she had reached an age when many would have retired, Dr Sofie continued her practice, commuting each day from the plantation to town in a new Ford — the first automobile owned by anyone in the county.

Dr Sofie died of a stroke at a hospital in Houston on July 21, 1925. She was 79.

At her request, she was buried with her lucky necklace — tangible evidence of her skills as a surgeon.

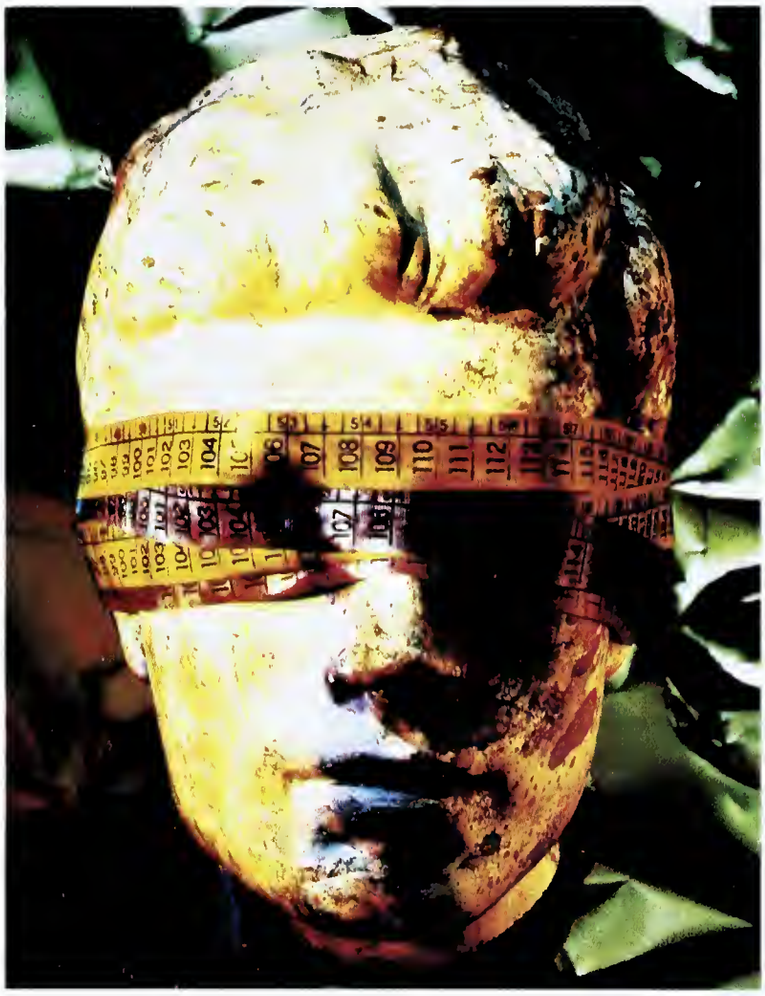
One of those attending her funeral was a Dr Retting, an old friend and colleague. The doctor told the writer of Dr Sofie's obituary for the *Houston Chronicle* that the citizens of Brazoria planned to build a monument in her memory. Dr Retting died not long after his friend, however, and the monument died with him.

But the doctor's memory lived on for years. As the *Chronicle* put it, "Brazoria, and indeed a large part of South Texas, loved and honored the woman physician who had ministered to so many people for more than a quarter of a century . . . her death has given thousands a sense of deep personal loss."

Mike Cox is an Austin writer and historian.

Physician report cards

It's not a question of *if*, but *how* you will be graded



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The scrutiny has already begun. The first annual health maintenance organization (HMO) report cards came out last fall. Next year, hospital discharge data will be aired publicly. And for the past 4 years, employer groups have been clamoring and lobbying heavily for physician profiling to begin.

Most observers agree it's only a matter of time before some form of rating physician performance hits the streets. But defining what data will be collected and how the data will be used offers Texas physicians an opportunity to control a train that's already left the station. ➤➤

By Laurie Stoneham

Who wants to know?

The government, employers, and consumers are demanding a way to judge what they're getting for their health care dollar. Sophisticated, information-thirsty consumers want access to the best care, while employers want to be able to evaluate value and return on their investment.

"For years and years we've said, 'We're good docs; trust us,'" said Josie Williams, MD, medical director of the Texas Health Quality Alliance and member of the Texas Medical Association Council on Socioeconomics. "But we have very little data on us as groups or as individuals to support that what we do is good quality of care. And I think we're at a level where folks are asking us for accountability," she said.

"There are significant variations that make little sense in health care," Dr Williams continued. "We don't have the data to know why one doctor has the same outcomes as another doctor and yet it costs him twice as much to take care of a patient."

Academic researchers are stirring the pot. After examining Medicare data, the *Dartmouth Atlas of Health Care in the United States* reported, "The amount of care consumed by Americans is highly dependent on where they live — on the capacity of the health care system where they live and on the practice styles of local physicians. Variations in the intensity of use of hospitals, the striking differences in the way terminal care is delivered, and the idiosyncratic patterns of elective surgery raise significant questions about the outcomes and value of health care."

Trends in Texas

To enhance health care quality and promote patients' accessibility to cost-effective quality health care, a 1995 legislative act created the Texas Health Care Information Council (THCIC). The 19-member council represents all stakeholders — employers, labor, physicians, hospitals, consumers, HMOs, and quality assurance experts — and is charged with gathering and objectively reporting HMO Health Plan Employer Data and Information Set (HEDIS) data and hospital discharge data annually. TMA has been active in refining the language of the original legislation to ensure that all data are presented accurately and will be meaningful for consumers.

THCIC is chaired by Stephen Turner, MD, a Plainview pediatrician. Other physician council members include Amanullah Khan, MD, a Dallas oncologist, and Robert Schorlemer, MD, an obstetrician-gynecologist in San Antonio.

Since the second quarter of 1998, licensed Texas hospitals, with the exception of rural facilities, have been required to collect and submit data to THCIC. The hospital discharge data, which are expected to be released in January 2000, will include at least 6 months of data, covering nearly 100 data elements that can be used to profile demographic, diagnosis, mortality, and length-of-stay information.

> "For years and years we've said, 'We're good docs; trust us.' But we have very little data on us as groups or as individuals to support that what we do is good quality of care. And I think we're at a level where folks are asking us for accountability."

Push to profile

During the last two sessions of the Texas Legislature, consumer and business groups have pushed to pass legislation that would require physician performance to be profiled. TMA has successfully blocked these efforts in Texas, but the tide is turning. Physician profiling is already under way in several states, including New York, Pennsylvania, and Florida.

"A lot of practice-specific information requested by policymakers or employers and consumers may be technically feasible to collect, but it is still prohibitively expensive to obtain, making the process unrealistic for most physician practices," said Helen Kent Davis, TMA director of governmental affairs. "Over time, new technology may simplify the process, yet the fundamental questions of what we want to collect, and why, must still be answered."

During the most recent legislative session, lawmakers passed House Bill 110. "Originally dubbed 'physician profiling,' it's really a physician disclosure bill," Ms Davis said. The bill, supported by TMA, enables information about physicians to be released by the Texas State Board of Medical Examiners (TSBME).

Currently, patients can readily find out where physicians received their training. However, HB 110 goes further, making it easier for patients to find out a physician's office hours, specialty services, and where he or she has hospital privileges. Regarding malpractice data, releasable information is limited to the results of the TSBME-required investigation when a physician has three or more claims in a 5-year period. The details of the claims themselves cannot be disclosed.

HB 110 represents "an initial step by the legislature of getting more information about physicians into the hands of patients," Ms Davis said.

Dancing with the data

The latest effort to gather data from hospitals has pointed out some systematic problems. First, the numbers are being collected from billing records because that's the only data readily and economically available that can be manipulated electronically.

"This is a system for reporting data to a payer to get paid — not to profile a physician. Yet, if used wisely, claims data can be a good starting point for assessing health care quality," Ms Davis said.

Denise Remus, PhD, RN, vice president of the Dallas-Fort Worth Hospital Council Data Initiative, says different payers have different documenting requirements. For example, THCIC requires race data to be reported;

however, race and ethnicity are not generally required for payment, and that information is not always entered into hospital billing systems. Something as simple as reporting a patient's race can mean a collection process has to be formalized by each hospital. Additionally, that particular data element has to be defined in a standard way because the letter "C" may signify Caucasian race for one payer, while the number "2" is used by another.

This past legislative session, TMA, the Texas Hospital Association, and the Dallas-Fort Worth Hospital Council worked with Rep Glen Maxey (D-Austin), the data council's legislative sponsor, and consumers to establish a "minimum data set" to ensure that the public-use data file contains only those data elements that have been verified for accuracy and consistency.

Limitations are placed on the data being gathered, according to Dr Remus, who also is chair of the THCIC Health Information System Technical Advisory Committee. "The billing format contains spaces for only nine diagnosis and procedure codes. This means that mortality studies should be interpreted with caution because the THCIC data may not capture the complete picture of a patient's underlying health problems and risk of death." For example, hospitals and physicians who treat patients with the most serious illnesses tend to have higher mortality rates, which do not reflect the quality of care the patients receive.

TMA again was active in modifying the legislation to require THCIC to attach severity and risk adjustments to all data and to include educational materials explaining data collection methods and limitations.

Whether these limitations are presented and explained in a manner that is easily understood by consumers remains to be seen. According to THCIC Chair Dr Turner, great emphasis has been placed on ensuring accuracy, including giving hospitals two opportunities to review, edit, and certify accuracy of the data. "We'll make every effort to make things as fair, understandable, and accurate as possible and would never intentionally release information that could deceive or mislead the public," Dr Turner emphasized.

> "We'll make every effort to make things as fair, understandable, and accurate as possible and would never intentionally release information that could deceive or mislead the public."

Inherent dangers

Despite these precautions, Norman Chenven, MD, president of the Austin Regional Clinic, thinks danger still lurks. "It's a realm that's poorly understood, and there's going to be a lot of information out there. There's a greater potential for malicious use of the data than there is for the beneficial use," he said.

The concern over how the data are used stems from the differing viewpoints of physicians, patients, employers, and health plans. While physicians want to use the data as an educational tool to improve the quality of care and patient outcomes, consumers and employers often see it as a way to identify

Preparing yourself

What, if anything, can you do to prepare yourself for what appears to be yet another regulatory onslaught? Here are some suggestions:

LEARN WHAT YOUR DATA LOOK LIKE. Talk to the utilization review and quality managers at your hospitals to see what sort of data they are gathering that will allow them to profile physicians internally.

VERIFY DATA. Urge your medical staff to play an active role in the verification of the hospital's discharge data. A TMA-supported amendment to the Texas Health Care Information Council (THCIC) statute allows physicians to review their data for accuracy and consistency. While no physician- or patient-specific data will be released by THCIC, physicians must be involved in assuring the reliability of their facilities' information.

START MEASURING YOURSELF. TMA's HeartCare Partnership is an interactive continuing medical education program that allows you to measure and better manage the care you provide to patients with cardiovascular disease risk factors. It's a solid way to begin designing a practice-based system for improving quality of care. For more information, contact Bridget Butler in TMA's Division of Science and Quality at (800) 880-1300, ext 1461, or (512) 370-1461; or e-mail bridget_b@texmed.org.

GET TO KNOW THE COUNCIL. Learn more about THCIC by accessing its Web site at www.thcic.state.tx.us.

JOIN THE COUNCIL. Better yet, get involved with the work of THCIC. There are several positions available for physicians. Contact the council in Austin at (512) 424-6492.

so-called "bad doctors." The data could be misunderstood and misinterpreted as used by health plans as an excuse to exclude physicians from their networks.

"I think what we're more likely to see is people in organizations using the data ignorantly, not understanding what the data really mean," said John Holcomb, MD, vice president for clinical services for the five-hospital Methodist Healthcare System in San Antonio.

Dr Chenven believes the motivation for profiling is a good one, but adequate tools are lacking. "It's not a bad desire to want to be able to measure quality of care or outcomes. That's a terrific idea. It's just scary when it gets out ahead of where we're going to be able to actually do it well and appropriately."

One of the key challenges of this whole issue is determining how to define and then measure quality of care. "The physician community is going to have to define for itself what it thinks are the true measures of quality care," Dr Holcomb said. "We're going to have to invest in our practices with data collection systems and then take those systems and those results forcefully to the marketplace to show that this is the correct measure of whether physicians are effective in patient care or not."

The inevitability of physician profiling

"Everyone should appreciate that every managed care company and every insurance payer right now is collecting profiling data on every individual physician and hospital," said Dr Holcomb, a member of the Texas Hospital Association Quality Council and also a member of TMA's Council on Socioeconomics.

"That same data being collected and displayed by hospitals also can be broken down so that it can be displayed by physician," Dr Holcomb said. "The information is already in the data banks, and the only thing that's being waited for is the go-ahead to produce physician-specific data from hospital discharge data."

> "I think the business community and the government's push to do profiling and measuring is just premature. I think the desire is mostly driven by economic concerns rather than quality concerns."

THCIC member Laura Stevens, director of medical reporting for the Harris Methodist Health System, believes physician profiling will come to Texas within the next 2 or 3 years. She says the emphasis should be on the quality of care provided and not on economic reports.

"I think the business community and the government's push to do profiling and measuring is just premature. I think the desire is mostly driven by economic concerns rather than quality concerns. I can understand it, but I think it's almost doomed to be a very unpleasant and unproductive experience for the next 10 years," Dr Chenven said.

"We can no longer afford to say, 'I don't have time to know what my quality of care is,'" Dr Williams offered. "We have to produce data. And the problem is somebody's going to produce the data for us and it's not going to be right. We have to know what our data are to defend, to change, or to improve physician profiling," she said.

"Control and evolution are what's needed. It just has to be done under some level of control in a sober way," Dr Chenven concluded. ★

Laurie Stoneham is an Austin freelance writer.

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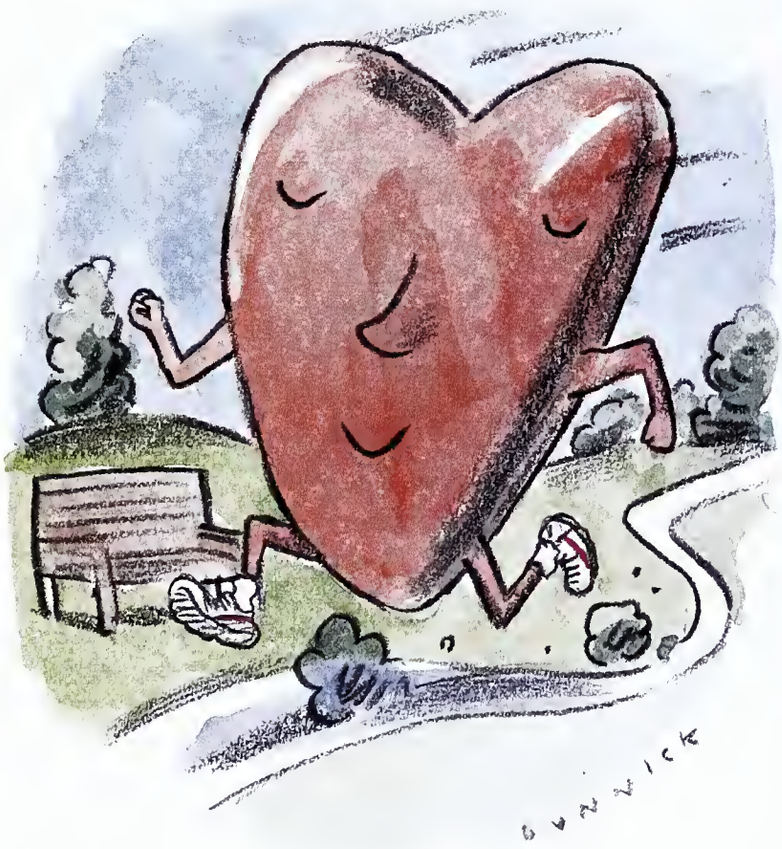
TexasMedical Association

Heart to heart

Project WATCH enters the fight against cardiovascular disease



Regan Dunnick

You can't remember the last time you walked a mile. Or when you actually ran one. Those few extra pounds are creeping around your waistline, and that half pack of cigarettes a day is taking a heavy toll on your precious lungs. And let's not even mention that your blood pressure is above normal or that your cholesterol numbers are way too high. With a lifestyle like this, you'll soon be a member of the cardiovascular disease and stroke club.

By Laura Albrecht,
TMA public information officer

But don't sign up for membership just yet. Help is on the way, not only for physicians but also for their patients to prevent cardiovascular disease, the No. 1 killer in Texas.

Texas Medical Association's Project WATCH is a cardiovascular disease and stroke prevention education program that will be unveiled at TMA's 1999 Fall Conference September 18 in Austin. (See "September 18 Fall Conference to Discuss Medicine's Turning Points," pp 16–17.) The 2-year program will focus on the five risk factors — weight, activity, tobacco, cholesterol, and high blood pressure — of the disease that in 1996 claimed 42,330 lives in Texas. Stroke took the lives of another 9,845 Texans.

"Project WATCH not only will benefit our patients but it also will bring awareness to the family of medicine," said TMA President-Elect J. James Rohack, MD.

The project is a cooperative initiative that includes the Councils on Communication, Public Health, and Scientific Affairs, the TMA Alliance, and the TMA Foundation. County medical societies also will be involved. The Committee on Cardiovascular Diseases will provide scientific and clinical advice. TMA President Alan C. Baum, MD, and Dr Rohack will direct the program, which is set for full implementation in 2000 and 2001.

The program's first order of business will allow physicians to review and assess their own risks for cardiovascular disease and stroke. Employing a domino effect, a scheduled exercise program combined with a good diet and no tobacco will help lead to normal cholesterol levels and blood pressure, and will allow physicians to encourage their patients to follow their example. Of course, genetics and family health history can play a role in a person's health.

"As physicians, we have to start paying attention to our own health," Dr Baum said. "We should all take this program to heart not only for our patients but also for our families."

The Houston ophthalmologist admits his biggest challenge is staying on an organized workout schedule. He says that like many others, he finds excuses to fall off a workout routine, but he is striving to develop more discipline to stay on schedule.

"This program certainly melds nicely with our image of physicians caring for all Texans," said Dr Rohack, a Temple cardiologist. "However, if we are going to be interacting with our patients, we should certainly be practicing what we preach."

TMA Alliance President Pam Hendricks, of Temple, says the program "will be a wake-up call to watch everything" that affects the health of physicians and their spouses.

Dr Robitaille firmly believes patients do pay attention to what their physicians do and that a healthy doctor translates into healthier patients. "Patients will come to me after switching from a doctor who's obese and smokes," she said. A physician who practices prevention in his or her own life promotes a healthy lifestyle to patients.

Patient education and prevention are mainstays in Dr Robitaille's practice. "Twenty-five percent of my time is spent practicing Western medicine and the rest of the time with a patient is prevention and education," she said.

"If you have balance in your life, then you are a better doctor."

"As physicians, we have to start paying attention to our own health. We should all take this program to heart not only for our patients but also for our families."

Fit as a fiddle

Austin physician Doris Robitaille, MD, glances at her pager one last time before huddling with her soccer teammates. It's a sultry evening at the Zilker Park soccer fields and she's ready for a strenuous cardiovascular workout that will bring relief from her day as a solo family practitioner.

Dr Robitaille has spent the last 7 months getting her new practice up to speed. Through it all, she's worked equally hard to pay attention to her own health regimen. She's kept up her physical activities, which, in addition to soccer, include running, cycling, backpacking, and shooting some hoops at home. She maintains a healthy diet that doesn't include caffeine or sweets. Tobacco is definitely not invading her body, and she reports that her blood pressure is normal and her cholesterol numbers are good. "It's all a personal choice," she said.

God, family, exercise, and country

Thirty minutes a day of exercise and a nutritional diet will ensure good cardiovascular fitness, says Brian Eades, MD, who sticks to a high-protein diet.

"I preach this stuff all day long," said Dr Eades, an Amarillo obstetrician-gynecologist who runs three times a week, lifts weights twice a week for 2 hours, and maintains a healthy diet. He tells his patients that deciding to put prevention in their lives is like moving to another country because everything changes.

Dr Eades says it can be overwhelming to many patients to address their weight, exercise, tobacco usage, cholesterol lev-

TMA Advantage: Take part in Project WATCH

Make plans now to roll up your sleeves to give some blood and take off your shoes to jump on the scales on Saturday, September 18. It's all part of the unveiling of Project WATCH at TMA's 1999 Fall Conference: Turning Points in Medicine at the Renaissance Austin Hotel.

By the end of the day, you'll know your weight, cholesterol level, and blood pressure. In addition, physicians and their spouses will be given exercise tips and information on the health risks of tobacco.

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els, and high blood pressure. "Growing up in West Texas, you hear the old adage, 'God, family, and country.' That should be, 'God, family, exercise, and country.' If you are not going to make it [good health habits] a priority, then it's always going to be the first thing to fall off your plate."

Making time to commit to a program is a major obstacle, but worth the trouble to overcome it. "If you promise yourself every day you are going to do something toward the betterment of your health, then it's really not that bad. Experts say if you do something regularly for a month, it becomes a habit," he said.

Those good health habits can be life-savers.

Good health in medical school?

Second-year medical student Katie Hurley Ostrom, of Houston, had good intentions of keeping her personal health program alive when she entered Baylor College of Medicine.

She was in for a major surprise. The former college field hockey player turned swimmer, runner, and cyclist discovered she had no time for anything but school.

"I was so overwhelmed at the beginning of med school that for the first 3 to 4 months I was down to riding my bike back and forth to class," she said. "I would probably get out once a week to do something else like swim, run, or lift weights, but I was terribly disappointed with that. I hated the fact I was not exercising on a regular basis."

Ms Ostrom knew that to succeed she would have to get on a schedule that would include exercise along with a healthy diet. She decided to set as her goal an upcoming race. "I actually started to get myself on a better schedule."

Pleased with her ability to get back on schedule, she went one step further and hired her husband's coach. "He put a schedule together for me according to the different weeks of school. On hard weeks he has me doing 30-minute daily workouts."

"One thing I have found amazing is that doing 15 to 30 minutes of exercise a day or every other day can make a difference," Ms Ostrom said. "I have

stayed so much stronger than I have ever been."

Exercise and a high-protein diet have benefited Ms Ostrom's sleep patterns and allowed her to focus more while studying. "I am actually able to study better and I have been able to avoid any caffeine to stay awake."

She says "being athletic and eating a healthy diet go hand-in-hand," adding that she avoids the fast food urge by keeping enough groceries at home so that a healthy meal becomes a reality. "Life just seems to flow a little bit better."

Taking prevention to heart

Dr Rohack believes physicians are in an excellent position to set an example for their patients through Project WATCH.

"Weight, activity, and use of tobacco are easily identifiable things patients can recognize about their physicians," he said. "A doctor who has nicotine stains on his or her hands and smells of tobacco smoke sends funny messages when urging a patient to stop smoking."

An acceptable cholesterol level is a matter of a prudent diet, and an active individual with an ideal body weight has less chance of developing hypertension. "Some studies show that mild hypertension can be controlled with diet and exercise," said Dr Rohack.

Dr Rohack's personal experience resulted in a closer look at his own health. "If you are not monitoring yourself, you can get into habits that lead to weight gain — that's what happened to me. My personal regimen was to get back to those health habits I knew would work for me, like exercising routinely and avoiding foods with high fat content."

Dr Rohack takes the stairs instead of the elevator at his office. And weekend chores at his ranch involve swinging an ax when wood needs to be cut.

The leaders of TMA and the alliance are committed to this unique program. "We have all known colleagues who were very important to their patients and communities," Dr Baum said. "But because they neglected their own health, those physicians had to retire earlier than they wanted to or they may not even be with us." ★

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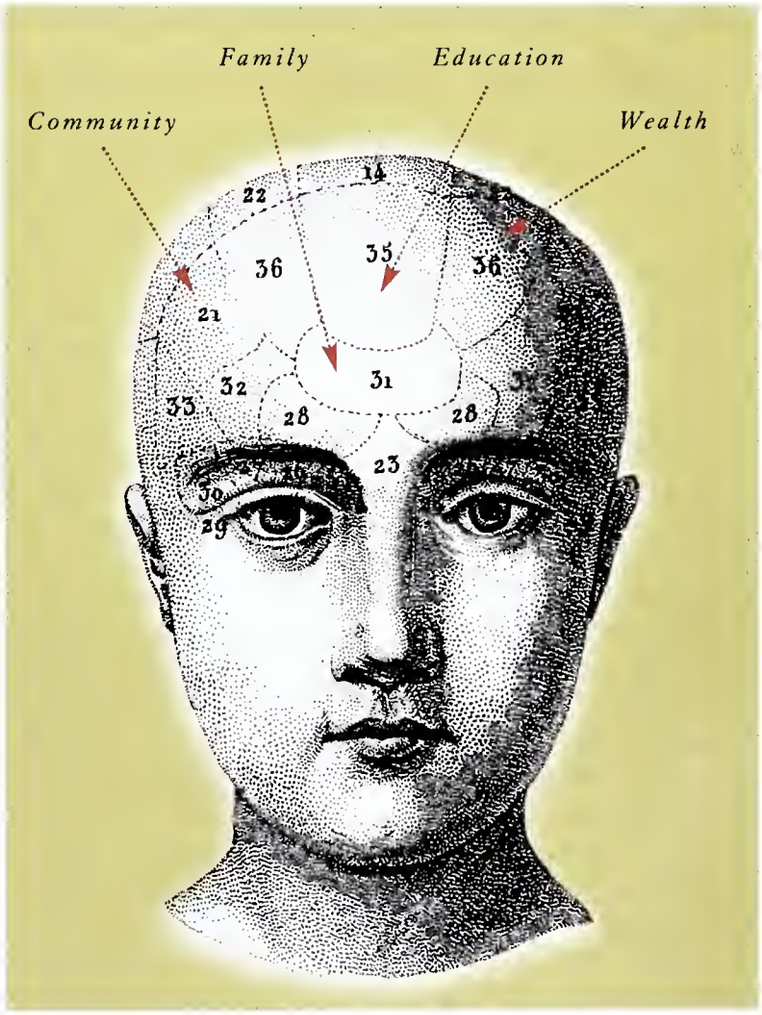
THE UNIVERSITY OF TEXAS-HOUSTON HEALTH SCIENCE CENTER

Why people get sick

An interdisciplinary study in Houston looks beyond disease

In the study of the social effects on health, an interesting consistency is revealed. Research shows that among the world's developed nations, countries with the greatest median income have the lowest mortality rates, while nations where a small percentage of the population has the majority of the wealth have higher mortality rates. The same inverse relationship holds true in a state-to-state comparison within this country.

But in Texas, the low mortality rate of Hispanics throws a wrench into one of the demonstrable laws of this field. For some reason, despite the prevalence of diabetes and the relative poverty of so many Hispanics in Texas, this group seems to live longer. ➤➤



By Monica Maldonado, Associate editor

Statistics from the Texas Department of Health show that Hispanics consistently have lower death rates than the overall population. In 1990, for instance, the death rate for Hispanics was 3.9 per 1,000, and the state's overall death rate was 7.4 per 1,000. Seven years later, Hispanics still rated a significantly lower death rate of 4.0, compared with that of the state at 7.

"One thing that comes to my mind as to why that's true is that the social fabric of Hispanics is considerably stronger than it is for other race groups," said John Ribble, MD, professor of medicine at The University of Texas-Houston Health Science Center (UT-Houston) Medical School and one of the researchers who will look into the anomaly. Something about the Hispanic culture of close families and strong faith, he guesses, gives them a kind of immunity that helps stave off death. So if the relationship exists, he asks, is it a causative relationship? If so, how does that play out physiologically?

Of course, Dr Ribble plans to figure this out. His follow-up research into Hispanic health will be a significant part of a large-scale undertaking beginning this month in Houston. There, UT-Houston, Rice University's Baker Institute for Public Policy, and eventually Baylor College of Medicine, The University of Texas M.D. Anderson Cancer Center, and the University of Houston will begin a project tentatively called the Texas Program in Society and Health. At its core, the program will investigate why some people get sick and others don't. Beyond that, it will build a body of scientific conclusions that is intended to influence public policy and lead to interventions that will result in healthier populations. It is an interdisciplinary project, to say the least.

At first glance, this may sound like the business of public health, and, indeed, it will involve researchers from that discipline. But the scope of the project really goes beyond what public health has traditionally addressed. "With public health, we start at the disease level and look at what the external factors are that affect it," said Palmer Beasley, MD, dean of the The University of Texas-Houston School of Public Health. But the scope of public health is beginning to change, he says. "Besides external factors, besides genetic makeup, there are factors that exist in terms of relationships among people," said Dr Beasley. The Houston research project, he explains, will approach health before the point of disease. "Both public health and medicine haven't seen as big a picture of health as they could."

"The only thing anyone has proposed as an explanation is that the key to health is a person's own sense of control. In one sense, the cause of death is irrelevant. It's merely an opportunist."

Uncovering the social determinants of health is not an entirely new field of research, but the Houston project differs in that it will apply the findings. Once researchers establish with certainty the factual basis for this field, they will research which ameliorative and fundamentally corrective interventions would most affect public health positively, and then put that information into language the public can understand and use to change health status.

"The way we approach health in the United States is wrong. We're just catching bodies as they fall off the treadmill," said David Low, MD, PhD, president of UT-Houston, who is credited with initiating the project. "And it's getting worse."

While Dr Low was training in both the United States and his native Canada, he became interested in how public policy relates to health care. His involvement in this issue on both sides of the border allowed him a unique perspective on health care delivery systems, one that was often called upon by administrators and policymakers. The Americans and Canadians were as interested as they were ignorant about the way they delivered health care, says Dr Low. "But nobody ever asked the basic question of why some people are healthy and others aren't. I think we have to look at the context in which disease occurs."

Dr Low points out that despite being the richest nation in the world and spending about a trillion dollars a year on health care, the United States falls into the lower fourth of developed nations in mortality rates. "We have abandoned health policy to an impersonal market," he said. "And the system itself is beginning to make people sick with worry about how they're going to pay their doctor bills."

In the United States, many of the factors the Houston project will explore — income, education, employment, family status, and others — are closely tied to race, and practicing physicians probably aren't ready to hear another accusation about the discrepancy between the health care of whites and other race groups. But researchers in the Houston project hope their work will take physicians, policymakers, and most importantly, the public, to a higher level of understanding of why people get sick. "The only thing anyone has proposed as an explanation," said Dr Low, "is that the key to health is a person's own sense of control. In one sense, the cause of death is irrelevant. It's merely an opportunist."

Framework for a "soft science"

In the field of social determinants of health, there is a famous study by Michael Marmot, a professor of epidemiology and public health at University College, London. His "Whitehall" studies, which began in the 1960s, found that among British civil servants, the lower the pay grade, the more likely men were to have poor health habits and have higher morality rates. Important as these factors are as predictors of disease, the differences among pay

grades did not explain the differences in mortality. A follow-up study showed differences in psychosocial factors, with lower grades reporting more monotonous work, lower perceived control over their work, and less job satisfaction.

The Whitehall studies set the stage for projects around the world, and science has since worked out two significant markers along the path of understanding how a person's perception of the world affects his or her health. For one thing, strong evidence indicates that the first 3 to 4 months of life are critical in brain development and that the more stimulation and affection a child receives at this time in life, the more synapses form in the brain. These connections form the basis for learning and contribute to a person's emotional resilience. "When we look at school failure, we need to look at what happened to these children as they grew," said Dr Low. "There may be physiological reasons for their failure."

There is also an enormous amount of evidence to suggest that stressful situations have biological consequences. When under stress, the body reacts by releasing hormones and adrenaline to help it respond to what it perceives as a threat, quickening the pulse and breathing and increasing blood pressure. But prolonged exposure can have damaging effects on the body. People in unhappy relationships, stressful jobs, or dangerous neighborhoods are all susceptible.

Because of the wide array of population types in Texas, researchers say, the state is fertile ground for studies of this type. Size matters here, as does the

Research roundup: A short list of research from around the state

THE UNIVERSITY OF TEXAS SOUTHWESTERN MEDICAL CENTER AT DALLAS — The same hormone in mice that regulates cryptorchidism may regulate it in human males, according to research by Luis Parada, PhD, director of UT Southwestern's Center for Developmental Biology, and Serge Nef, PhD. Cryptorchidism, or impaired testicular descent, is a congenital abnormality that affects 2% to 3% of full-term boys at birth. If the condition is not corrected, usually by surgery, by the age of 2, it increases the risk of testicular cancer and reduced fertility. The experiment, reported in the July issue of *Nature Genetics*, shows that fluctuations in the level of hormone Ins13 greatly influence the state of testicular descent in mice, and the researchers believe the same holds true for humans. Dr Parada believes that by giving the boys an additional dose of hormone, the risks of surgery and cancer would be eliminated.

THE UNIVERSITY OF TEXAS MEDICAL BRANCH AT GALVESTON — A binding protein called IGFBP-2, part of the network of molecules that regulates cell growth, may be the key to controlling the growth of prostate cancer cells, according to research by Shilla Chakrabarty Chatterjee, assistant professor of anatomy and neurosciences at The University of Texas Medical Branch at Galveston. She believes that in older men, the IGFBP-2 protein stimulates IGF-1, a growth factor that causes prostate cells to divide, which in turn jumpstarts the cancer-starting process. Though her findings are preliminary, Ms Chatterjee believes this discovery may lead to an easier way to diagnose prostate cancer and eventually a way to manipulate the expression of the binding protein, causing the prostate cancer to shrink or disappear.

BAYLOR COLLEGE OF MEDICINE — Baylor hopes to recruit 1,800 people for a study on whether a stronger dose of the chicken pox vaccine will prevent shingles in older adults. The same virus that causes chicken pox — varicella-zoster — can reactivate in older adults who had chicken pox as children, traveling down the nerves to the skin where it causes a painful rash on one side of the body. Though the rash heals, extreme pain from damaged nerves can persist for years. Wendy Keitel, MD, principal investigator, says the vaccine they will be testing will boost the immunity from the virus that lingers but declines in people who have had chicken pox. Participants will be monitored over 5 years to determine their immunity.

UNIVERSITY OF NORTH TEXAS HEALTH SCIENCE CENTER — Based on research by the University of North Texas Health Science Center and Wilford Hall Medical Center in San Antonio, the US Food and Drug Administration recently approved the drug lovastatin (Mevacor) for use in reducing the risk of a first heart attack. The researchers found that lovastatin, originally a cholesterol-lowering medicine, reduces the occurrence of heart attacks and other coronary events by 37% in men and women who have average levels of LDL, but reduced levels of HDL.

THE UNIVERSITY OF TEXAS HEALTH SCIENCE CENTER AT SAN ANTONIO — Replacement of a defective gene called the RB gene slows or prevents the development of lung metastasis and suppresses tumors in the pituitary, thyroid, and adrenal glands in mice. The study, lead by Alexander Nikitin, MD, PhD, shows that an RB deficiency is important during tumor formation, even during the most advanced stages. The team hopes replacing the RB gene in human RB-deficient tumors, such as small-cell lung cancer, would be effective therapy.

mixture of races, social and economic classes, and geographic conditions. Also worthy of comparison are immigrant versus third-generation Mexican Americans, migrant versus permanent workers, married versus not-married, and possibly other groups.

By creating a multifaceted picture of health in Houston and Texas, the project can compare health outcomes among these groups. UT-Houston will follow five lines of study:

- The neurobiology of the human brain;
- The relationship between the brain and the immune system;
- Extension of the understanding of the determinants of health;
- The way in which a personal sense of control can affect health; and
- The relationship between spirituality and health.

"Some aspects of it are clearly soft science," said Dr Ribble. "And many of us who have worked in biomedical science can get impatient with uncertainty. But I think most of us feel that these social factors influence the function of the body in a measurable way."

The scope of the study requires some new hires. The most important of these is Alvin Tarlov, MD, previously professor of health promotion at Harvard School of Public Health and professor of medicine at Tufts University. Dr Tarlov will have a dual post at both Rice and UT-Houston. With experience as a physician and in public health and policy, Dr Tarlov is in a unique position to guide the program. He chairs the Advisory Committee for Population Health for the Canadian Institute for Advanced Research and the Harvard Interfaculty Initiative on Mind/Brain/Behavior: Society and Health; and serves on the advisory board of the International Centre for Health and Society at University College, London.

An important research challenge, Dr Tarlov says, will be to understand why improving the health of the lower class improves the health of the population overall. He says communicating this finding to policymakers might help sell some of the program's suggested initiatives.

"Some aspects of it are clearly soft science. And many of us who have worked in biomedical science can get impatient with uncertainty. But I think most of us feel that these social factors influence the function of the body in a measurable way."

Between medicine and public health

Traditionally, says Dr Beasley, public health and medicine haven't exactly been on the same page. "Physicians look at people one by one as they get sick, whereas public health is dealing essentially with people before they get sick, trying to keep them healthy. We don't really use the same vocabulary."

Each of the disciplines might have a touch of tunnel vision when it comes to the approach to health, but Dr Beasley argues that the real strides in health outcomes have come from public health. "More than 90% of the total dollars for health is spent on diagnoses and treatment of disease, and the rest is spent on what public health does. I ask, where are we getting the most bang for our buck? In the 20th century, that's been in public health."

Life expectancy in this country has increased by at least 20 years, he argues, since the introduction of public health initiatives such as immunization and water chlorination. But he adds that neither physicians nor public health professionals alone can improve the health of society, and an important aspect of the project will be to improve the communication between medicine and public health. That will include adding cross-disciplinary courses to the medical school and public health school curricula that introduce students to these ideas about social determinants.

In the meantime, Dr Tarlov suggests physicians can use this information now to improve the health of their patients. "For example, as an internist, I would want to be more medically aggressive with a patient who has had less than a high school education. I would make sure the patient really believes he has access to medical care. I would prescribe a more intensive treatment, and I would take extra measures to assure that the patient adheres to that treatment.

"But I haven't said anything about social issues. Well, a high proportion of doctors serve on important bodies that influence social structure. I think over the years of practice and being alert to our hierarchical structure, doctors would engage themselves in public discussion about work conditions, wages . . . and be an important voice in the community."

Curing societal ills would be a side effect to what researchers for the Houston project hope to accomplish in the end — a healthier population. As the American Medical Association adds educational programs on cultural competency, the theories presented by Dr Tarlov and others add a new dimension to the issue of working with minorities. "You can't fault racism solely for the poor health of the African American population," said Dr Tarlov. "You also have to understand that there's something about racism that gives blacks a sense they are not valued or wanted in society, which we believe affects the sense of control in their lives."

In the end, Dr Tarlov says, helping people gain a sense of control over their lives — whether it be through programs that help them stay in school, give tax breaks to married couples, provide transportation, or give them a sense of value as employees — may be the key to a healthier population. ★

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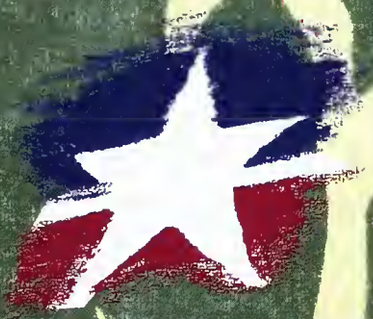

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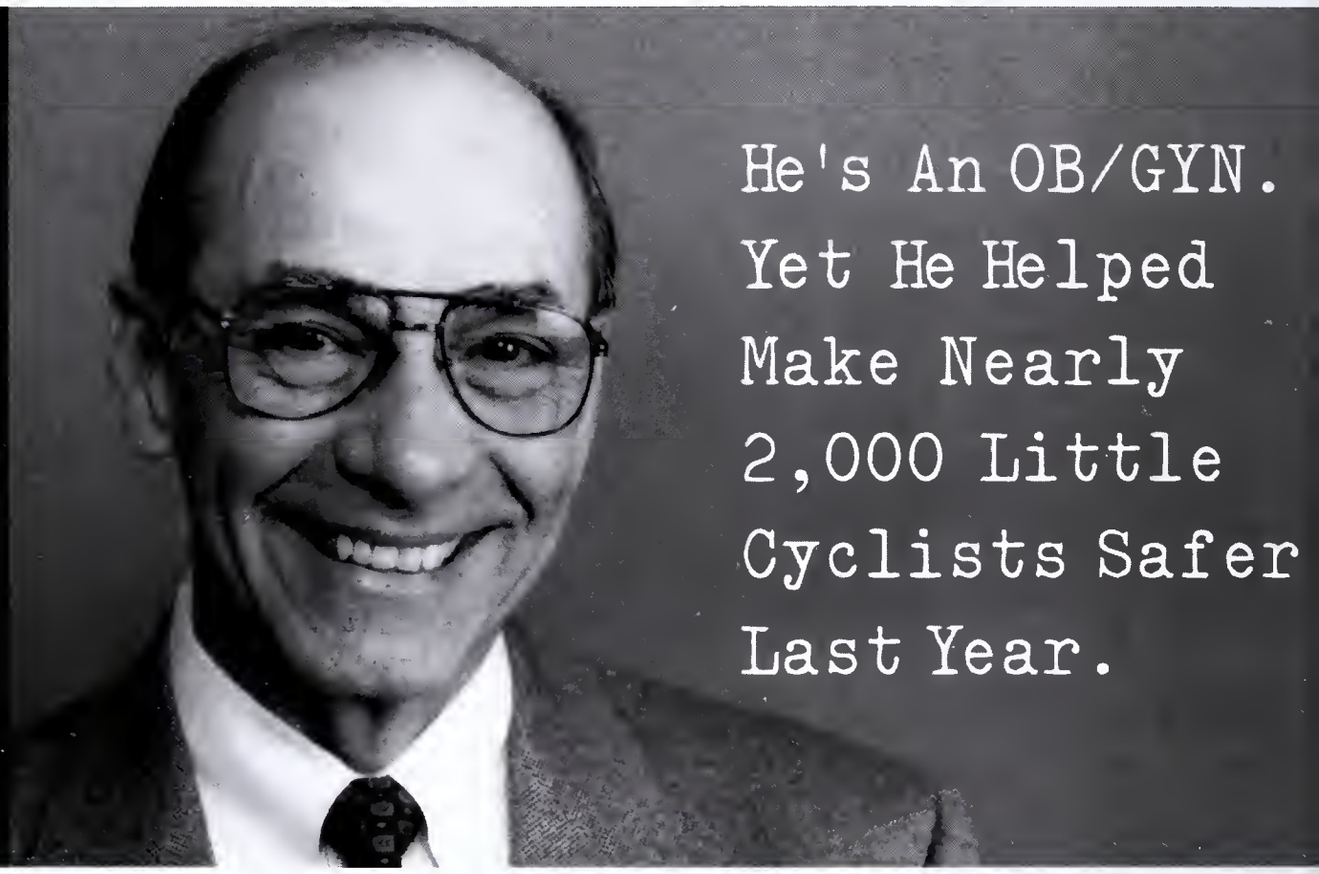

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Rates of abnormalities and infectious agents in cervical smears from female inmates in Texas: comparison with private and university clinic patients

ROBERTO LOGRONO, MD JICK Y. WONG, MS, CT(ASCP), MT(ASCP)

Inmates are generally considered a high-risk population for gynecologic neoplasia and sexually transmitted diseases. Cervical smears from prisoners of the Texas Department of Corrections (TDC) were expected initially to have higher rates of cellular abnormalities and infectious agents than do smears from the general population.

The cytologic findings from 25,522 TDC gynecologic smears were compared with those of 6883 cases from The University of Texas Medical Branch (UTMB) affiliated physician private clinics, and with 56,178 from the UTMB hospital clinics. The period of study was from September 1995 to February 1998.

This study revealed a 5.23% higher rate of abnormalities for TDC gynecologic smears as compared with that for the private clinic smears. However, the TDC rate of abnormalities was unexpectedly 1.08% lower than that for the UTMB clinic smears. These unexpected findings were probably the result of a more selected high-risk population referred to the UTMB clinics. The TDC smears showed also the highest incidence of trichomoniasis.

This study was partially presented in abstract form at the 46th annual scientific meeting of the American Society of Cytopathology, Nashville, Tenn, November 1998.

Send reprint requests to Dr Logrono or Mr Wong, Cytopathology Division, The University of Texas Medical Branch, 9.300 John Sealy Annex, 301 University Blvd, Galveston, TX 77555-0548.

INTRODUCTION

Since September 1995, the Cytopathology Laboratory of The University of Texas Medical Branch (UTMB) at Galveston has been processing Pap smears from inmates of the Texas Department of Corrections (TDC) system. Women prisoners are considered generally to be at higher risk for developing cervical neoplasia (1–4) and sexually transmitted disease (5–7), because most inmates come from the lower-income socioeconomic strata, which are associated usually with limited access to health care. Therefore, we expected that cervical smears from the TDC clinics would show much higher rates of cellular abnormalities and sexually transmitted diseases than would smears from the general population. The purpose of this study was to investigate the rate of cellular abnormalities and the prevalence of gynecologic infection in Pap smears from the TDC inmates. We compared these findings with those identified in gynecologic smears from the UTMB-affiliated private physician clinics and from the UTMB clinics.

METHODS

The cytologic findings of 25,522 gynecologic smears from the TDC clinics were analyzed and compared with those of 6883 cases from the UTMB-affiliated private physician clinics, and of 56,178 from the UTMB clinics. Smears were obtained from September 1995 to February 1998.

Using standard criteria for cervicovaginal cytological diagnoses (8), we reported data obtained from smears as unsatisfactory, within normal limits (WNL), or abnormal; the abnormal categories were tabulated and compared. The abnormal categories included atypical squamous cells of undetermined significance (ASCUS), atypical glandular cells of undetermined significance (AGUS), low-grade squamous intraepithelial lesion (LSIL), high-grade squamous intraepithelial lesion (HSIL), and carcinoma (CA), either squamous or adenocarcinoma, as described previously (8).

The rates of infectious agents identified cytologically on these smears were calculated and compared also. The infectious microorganisms categories included trichomonads, fungi of the Candida species, herpes virus cytopathic effect, and human papilloma virus-associated cellular changes.

RESULTS

The rate of abnormalities (ASCUS, AGUS, LSIL, HSIL, and CA) for Pap smears from TDC was 11.81%. The TDC results were 5.23% higher than the rate of abnormalities (6.58%) for Pap smears from the private physician clinics. However, the TDC rate was found to be 1.08% lower than that for smears from the UTMB hospital clinics (12.88%) (Table 1, Fig 1). The HSIL rate for the TDC smears was higher than that for either the private physician clinics or the UTMB clinics. The rates for carcinoma, LSIL, and ASCUS for the TDC smears were higher than those from the private physician clinics and lower than those from the UTMB clinics. The AGUS rate for TDC smears was higher than that for the private physician clinics but was almost the same as that for the UTMB clinics (Table 1, Fig 1).

The TDC gynecologic smears also showed the highest incidence of infection by trichomonads, followed by the UTMB clinics; the private clinics showed the lowest (Table 2, Fig 2). The rate of infection by fungi of the Candida species was lower in the smears from TDC than in those from the private physician clinics and the UTMB clinics. However, the rates of Herpes virus infection were similar among the 3 groups. Human papilloma virus-associated cellular changes

were identified most often on smears from the UTMB clinics and least often on those from the private clinics.

DISCUSSION

Previous reports indicate that female prisoners have a higher incidence of cervical cellular abnormalities (1–4) and sexually transmitted diseases (5–7) compared with the general population. Several explanations have been provided to explain the higher occurrence of cervicovaginal disease, neoplastic or infectious, in inmates. These include increased sexual promiscuity, history of prostitution, drug addiction, poverty, and limited access to health care, as well as the fact that inmates often come from the lower-income socioeconomic groups (1–7)

Upon admission to the TDC, female prisoners usually undergo a health check that includes screening for sexually transmitted disease and for abnormal cervical cytology. This initial screening is followed up with all necessary treatment and with routine annual examinations. In contrast, many indigent women often have no access to routine gynecologic examination or treatment of disease.

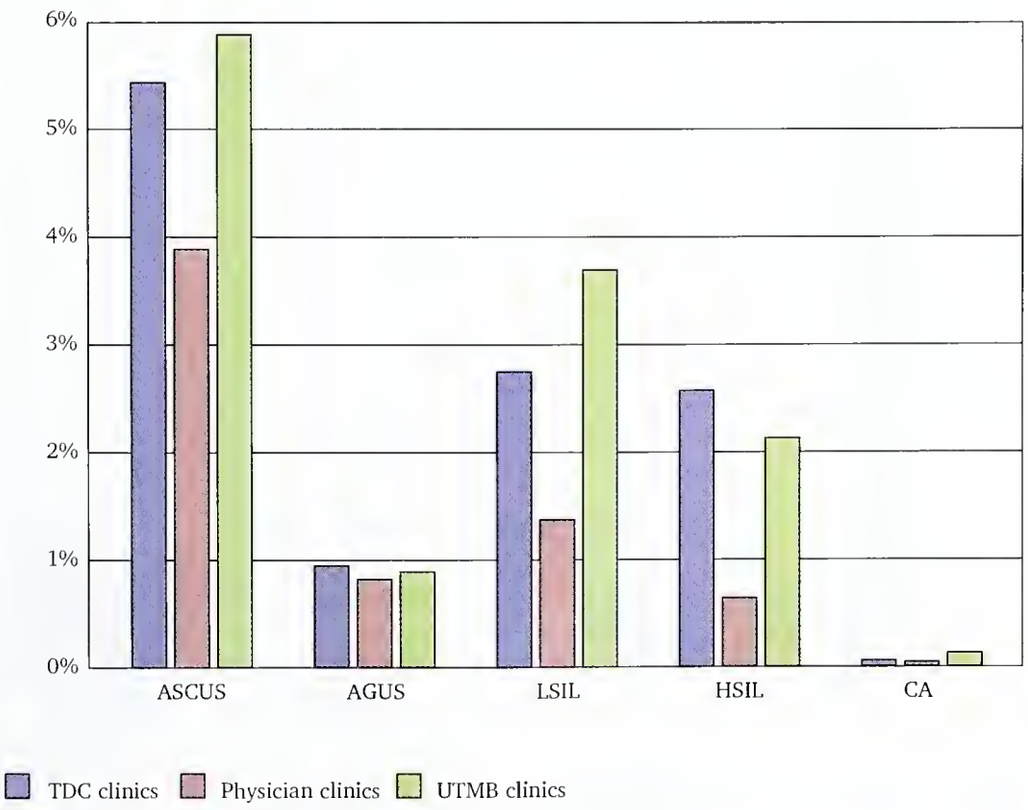
In our study, the overall rate for abnormal Pap smears for the TDC was significantly higher than that for the private physician clinics; however, the TDC rate was slightly lower than that for the UTMB hospital clinics. Finding higher rates of abnormalities in cervical smears from the UTMB clinics, as compared with those from the TDC inmates, although unexpected, was not totally surprising. This can be explained probably by the fact that large numbers of patients who are at high risk for gynecologic disease are referred to the UTMB hospital clinics. These high-risk patients include indigent women seeking medical care at UTMB hospital clinics as well as many pa-

Table 1. Diagnostic classifications of Pap smears from TDC clinics, UTMB affiliated physician clinics, and UTMB hospital clinics.

	TDC Clinics		Physician Clinics		UTMB Clinics		Total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)
ASCUS	1,401	(5.49)	266	(3.86)	3,303	(5.88)	4,970	(5.61)
AGUS	244	(0.96)	54	(0.78)	529	(0.94)	827	(0.93)
LSIL	707	(2.77)	91	(1.32)	2,070	(3.68)	2,868	(3.24)
HSIL	647	(2.54)	42	(0.61)	1,236	(2.20)	1,925	(2.17)
Carcinoma	14	(0.05)	1	(0.01)	99	(0.18)	114	(0.13)
Unsatisfatory	133	(0.52)	11	(0.16)	217	(0.39)	361	(0.41)
WNL	22,376	(87.67)	6,418	(93.24)	48,724	(86.73)	77,518	(87.51)
Total cases	25,522		6,883		56,178		88,583	

ASCUS = atypical squamous cells of undetermined significance
AGUS = atypical glandular cells of undetermined significance
LSIL = low-grade squamous intraepithelial lesion
HSIL = high-grade squamous intraepithelial lesion
WNL = within normal limits

Fig 1. Comparison of rates for abnormal Pap smears from TDC clinics, UTMB-affiliated physician clinics, and UTMB hospital clinics.



tients from other county hospitals and clinics who are referred to UTMB tumor clinics for treatment. The latter most likely explains the higher rates for abnormalities found in the UTMB clinic cervical smears. Therefore, the high rates of abnormal cervical smears obtained from patients of the UTMB hospital clinics should not be considered as representing the general population.

In contrast to the more selected UTMB hospital clinic patients with abnormalities, cervical smears from the private physician clinics were more consistent with the general population. Our study indicated that the overall rate for abnormal Pap smears from the private physician clinics was 5.23% lower than that from the TDC clinics and 6.31% lower than that from the UTMB hospital clinics.

Finding a high incidence of trichomonas infestations in the TDC smears was no surprise as sexually transmitted diseases are generally more prevalent in inmates. In our experience, the rate of trichomonas infestation on Pap smears from the TDC clinics was 14.73% higher than that for smears from the private physician clinics and 11.72% higher than that for the UTMB hospital clinics. Other series (2–4) have reported higher rates of trichomonas infestation in female prisoners than the current study.

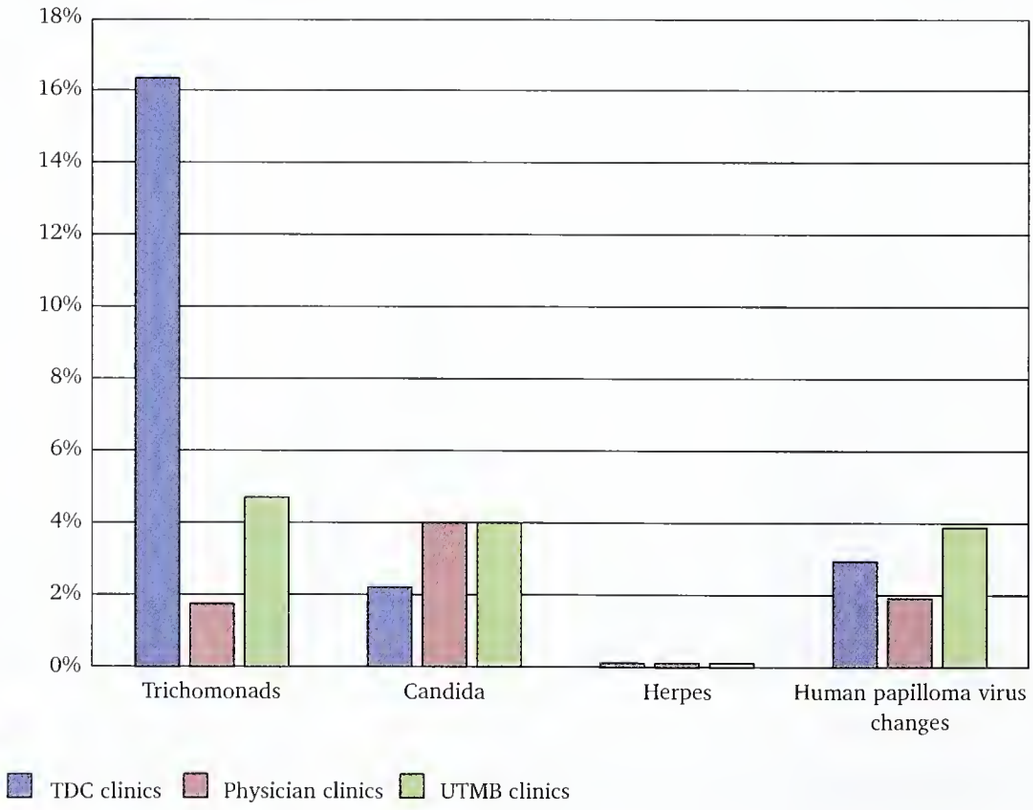
Although the rates of cervical neoplasia are higher in female prisoners than in the general population, this gap has narrowed in recent years. This trend was first observed by Karsai et al (1) in 1988 and was corroborated by the results of the present study. We believe that in the last 40 years, marked improvement has occurred in the health care system of the Texas prisons. In contrast, changing lifestyles and limited access to health care for low socioeconomic groups in the general population may explain the closing gap for cervical abnormalities and sexually transmitted diseases. Nevertheless, with growing budget constraints, the health care system continues to face significant challenges. A reasonable, cost-efficient solution must be sought to improve the health care access for the indigent population in the next century.

Table 2. Infectious agents on Pap smears from TDC clinics, UTMB affiliated physician clinics, and UTMB hospital clinics.

	TDC Clinics		Physician Clinics		UTMB Clinics		Total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Trichomonads	4,190	(16.42)	116	(1.69)	2,638	(4.70)	6,944	(7.84)
Candida species	596	(2.34)	274	(3.98)	2,265	(4.03)	3,135	(3.54)
Herpes	21	(0.08)	4	(0.06)	42	(0.07)	67	(0.08)
HPV changes	747	(2.93)	125	(1.82)	2,185	(3.89)	3,057	(3.45)

HPV = human papilloma virus

Fig 2. Comparison of rates for infectious agents on Pap smears from TDC clinics, UTMB-affiliated physician clinics, and UTMB hospital clinics.



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Ethnic differences in HIV testing

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Testing plays an important role in the early detection of human immunodeficiency virus (HIV) infection and in the formulation of an appropriate management plan for patients who are infected with the virus. Statistical data from the City of Houston Health Department were reviewed for persons who were screened for HIV during 1996 to determine their demographic characteristics, counseling status after testing positive, and availability of medical insurance. Records of 29,085 persons were reviewed in Houston during 1996. Eight hundred eleven cases (3%) tested positive for HIV. Seventy-three percent of the HIV-positive persons received post-test counseling, and 82% of the HIV-positive persons had no health insurance. Of the total number of positive tests, 53% were African American; 28%, white; and 17%, Hispanic. Counseling after a positive test can be an important preventive measure for persons known to be at high risk for the disease.

A paper presentation of this work was presented at the National Conference of Hispanic and Latino Studies, February 10–14, 1998, Houston, Tex.

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INTRODUCTION

This research attempts to improve awareness by characterizing HIV testing in Houston, Tex, and by providing information on the prevalence of HIV risk factors, ethnic differences existing in testing for HIV, services, and availability of medical insurance. Testing plays an important role in the early detection of HIV infection and in the formulation of an appropriate management plan for patients who are infected with the virus. Texas ranks fourth among all of the United States in total acquired immunodeficiency syndrome (AIDS) cases, exceeded only by New York, California, and Florida. Houston ranks fifth among US cities in total AIDS cases (1). Recent increases of HIV infection have been observed among African Americans and Hispanics who are infected through high-risk sexual and drug-related behaviors. The epidemiology of AIDS in Texas appears to be following the national pattern that affects an increasing proportion of females and ethnic minorities. Texas also is following the national trend with an increasing percentage of cases reported in the heterosexual population (1).

The prevention of HIV transmission through changes in sexual, reproductive, and addictive behavior is initiated often through counseling and testing services (2,3). For persons already infected, counseling and testing provide early detection of HIV infection and referral for optimal medical management and partner notification. The City of Houston Health Department, like other public health agencies throughout the country, offers programs for prevention, counseling, testing, and early intervention for HIV and AIDS (2,3). Indications for HIV testing include birth to a mother who is HIV infected or at risk for HIV infection (eg, a drug user or the sexual partner of a person who is a drug user, bisexual, or HIV positive) or who received blood or blood products before 1985. Other features that should be considered as indications for HIV testing include a history of sexual abuse in a child or adolescent, male homosexuality or bisexuality, and multiple sex partners (4).

METHODS

Statistical data from the City of Houston Health Department were reviewed for persons who were screened for HIV between January 1 and December 31, 1996, to determine their demographic characteristics including age, sex, race, risk factors for HIV transmission, counseling status after testing positive, and availability of medical insurance. Initially, records for 31,254 people were available from the City of Houston Health Department; however, 2169 people were not tested for various reasons, and their records were not reviewed for this study. Thus, records of 29,085 persons were reviewed for the relevant information.

Testing and counseling were conducted at different sites throughout Houston. Each of these sites had contracted with the City of Houston, Department of Health and Human Services, to provide free, voluntary HIV counseling and testing services (CTS). All sites had integrated CTS into their operations. Designated sites included sexually transmitted disease (STD) clinics, drug treatment centers, family planning services, community and public health clinics, and other facilities that provide these services. Data regarding demographic descriptions, self-reported risk exposure, and availability of medical insurance were reviewed. Counseling sessions were conducted according to standards established by the agency. Two types of tests are performed: *anonymous*, which have no identification, and *confidential*, which are kept private. The term "anonymous" is used when the persons ordering and per-

Table 1. Summary statistics of 31,254 clients tested for HIV in Houston in 1996.

Characteristics	No. (%)
Records	
Tested	29,085 (93)
Not tested	2,169 (7)
Reason not tested:	
Client declined	1,967 (91)
Referred elsewhere	5 (0)
Previously positive	9 (0)
Previously negative	33 (2)
Other	155 (7)
Type of test	
Anonymous	6,229 (21)
Confidential	22,754 (78)
Not specified	102 (0.3)
Test results	
Positive	811 (3)
Negative	28,185 (97)
Inconclusive	15 (0)
No result	74 (0)

Table 2. Demographics of 29,085 clients tested for HIV in Houston in 1996.

Characteristics	No.	(%)	Positive Test	(%)	Positive Post-test	(%)
Gender						
Male	13,380	(46)	618	(76)	446	(72)
Female	15,704	(54)	193	(24)	145	(75)
Not specific	1		0		0	
Total	29,085	(100)	811		591	(73)
Race						
African American	14,422	(50)	430	(53)	315	(73)
White	6,691	(23)	230	(28)	163	(71)
Hispanic	7,518	(26)	139	(17)	104	(75)
Asian/Pacific Islander	275	(1)	4	(0)	3	(75)
American Indian	48	(0)	1	(0)	1	(100)
Other	130	(0)	7	(1)	6	(86)
Age, in years						
< 5	12	(0)	1	(0)	1	(100)
5-12	39	(0)	1	(0)	0	(0)
13-19	6,255	(22)	37	(5)	30	(81)
20-29	10,809	(37)	258	(32)	181	(70)
30-39	7,263	(25)	334	(41)	242	(72)
40-49	3,530	(12)	141	(17)	105	(74)
> 50	1,173	(4)	39	(5)	32	(82)
Insurance						
None	24,344	(84)	666	(82)	490	(74)
Self-insurance	842	(3)	27	(3)	16	(59)
Public assistance	1,155	(4)	30	(4)	23	(77)
Military/VA	61	(0)	5	(1)	4	(80)
Employer insured	2,424	(8)	74	(9)	52	(70)
Not specific	259	(1)	9	(1)	6	(67)

VA = Veterans Administration

forming the test do not maintain a record of the name or identity of the person whose blood they are testing. In "confidential" HIV testing, the results of a test are known only to the person who is being tested and the immediate group of people who provide care and prevention services for that person.

RESULTS

Clear racial and ethnic differences exist in the proportion of HIV testing and in the exposure categories associated with AIDS. Table 1 presents the test statistics for the 29,085 persons whose records from 1996 were reviewed by the City of Houston Health Department. Seventy-eight percent of the tests were confidential and the rest were anonymous; 97% yielded negative results.

Table 2 presents demographics of the persons tested: gender, race, age, and insurance. Those who tested positive tended more often to be male, African American, and aged 30 to 39 years, followed by 20 to 29 years, and then by 40 to 49 years; most (82%) had no health insurance.

Table 3 shows characteristics of the reported risk exposure. Male-to-male sexual contact, alone and together with intravenous drug use, accounted for 13% of those tested and 51% of positive tests. Although 4% of the clients tested refused to acknowledge any risk behavior, this group accounted for 2% of positive cases. Less than 1% of positive cases resulted from sexual assault, perinatal transmission, and health care exposure. While some in high-risk groups may still be unaware of the availability of testing or of their risk for infection, others may deny their risk or be deterred by their fears.

Table 4 shows that 16,394 (56%) of the 29,085 persons tested received post-test counseling. This return rate varied significantly by client demographics, self-reported risk exposure, and HIV serostatus as shown in Tables 2 and 3. Seventy-three percent of clients with positive test results returned for post-test counseling. In general, members of racial or ethnic minorities were found to have post-test counseling rates higher than those of nonminority clients: Hispanic, 75%; African American, 73%; and white, 71%. In terms of age, clients older than 50 years had the highest rate of return for post-test counseling, followed by the group aged from 13 to 19 years.

DISCUSSION

The findings of this study confirm previous work (2) and indicate that demographic variables as well as reason for visit, HIV risk exposure, and serostatus were all associated with post-test counseling return rates in public-funded clinics. These findings cannot be generalized to the entire population in this metropolitan area because they are limited to describing those who voluntarily sought testing for HIV at facilities for which services were available without charge. Almost three quarters of HIV-positive clients returned to receive post-test counseling. Clients tested learn more than their test results: the post-test session can serve as a prevention mechanism for clients known to be at high risk for the disease. More active steps are needed to address the problem of subjects failing to return for the test results and post-test counseling. In addition, the client has an opportunity to modify behavior to decrease HIV transmission and to quality for certain health and human services.

Development of effective educational and counseling programs for prevention of HIV transmission is an important public health priority, particularly for African American and Hispanic communities. Minorities are reluctant to undergo HIV testing, and those of a low socioeconomic status warrant special attention in public health strategies to prevent AIDS because their risk of contracting AIDS is disproportionately high (5,6). Furthermore, many members of racial or ethnic minority groups may not know about, have access to, or trust services. Educational campaigns should be designed to overcome these misconceptions and to encourage all who may conceivably be at risk to seek testing (3). Minorities must explore also ways of involving other public and private entities, such as churches and community-based organizations that have access to the persons at highest risk (6,7). We recommend further research in this area to decrease the number of clients tested who acknowledged no risk factors. Such research is essential when the intervention aims to change behaviors that are embedded in a cultural context that is not well understood (7,8).

Table 3. Risk of HIV exposure of 29,085 clients tested for HIV in Houston in 1996.

Risk Exposure	No.	(%)	Positive Test	(%)	Positive Post-test	(%)
MMS and IDU	428	(1)	47	(6)	38	(81)
MMS	3,588	(12)	362	(45)	254	(70)
Heterosexual IDU	1,851	(6)	70	(9)	58	(83)
Sex partner at risk	5,339	(18)	141	(17)	105	(74)
Child of HIV woman	12	(0)	1	(0)	1	(100)
STD diagnosis	4,899	(17)	63	(8)	42	(67)
Sex for drugs/money	1,915	(7)	26	(3)	21	(81)
Hemophilia/blood recipient	195	(1)	4	(0)	3	(75)
Victim sexual assault	212	(1)	3	(0)	2	(67)
Health care exposure	73	(0)	2	(0)	0	(0)
No acknowledged risk	1,221	(4)	13	(2)	11	(85)
Other	9,344	(32)	79	(10)	56	(71)
Not specified	8	(0)	0	(0)	0	(0)
Total	29,085		811		591	

MMS = male-to-male sex
IDU = intravenous drug use
STD = sexually transmitted disease

Table 4. Post-test counseling sessions of 29,085 clients tested for HIV in Houston in 1996.

Post-test Counseling	No.	Received Test Counseling	(%)
All tests	29,085	16,394	(56)
Positive	811	591	(73)
Negative	28,185	15,779	(56)
Inconclusive	15	7	(47)
No results	74	17	(23)

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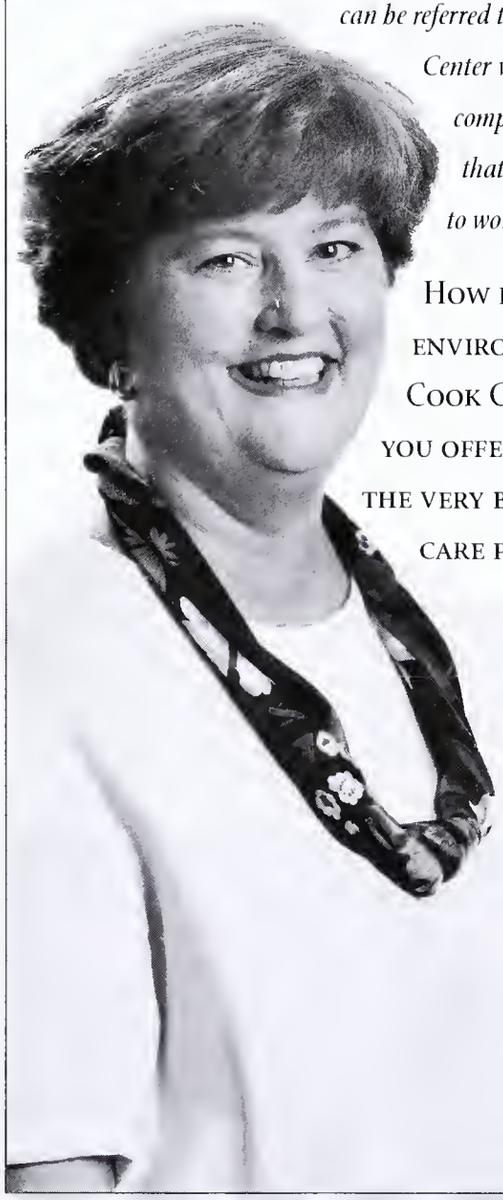

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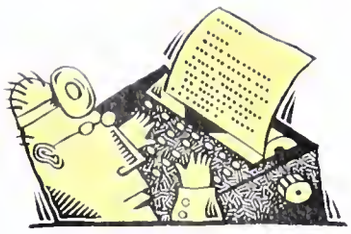

Letters

Alcohol not all bad

I would like to take issue with the cover of the August 1999 issue of *Texas Medicine*. While the article in general was quite laudable, I believe the commandment "Thou shalt not drink alcohol" is excessive, as well as erroneous. I am sure that I am one of many physicians who feel that appropriate use of alcohol products, especially wine with meals, is a reasonable part of a healthy lifestyle.

It is interesting that the commandment relating to drug states, "Thou shalt not abuse drugs," not "use drugs." To suggest abstinence from alcohol as a health benefit should be supported by scientific evidence.

Gary R. Hart, MD
3201 W Hwy 22
Corsicana, TX 75110

Physicians do counsel patients

I am writing regarding "Choosing Change" in the August 1999 issue of *Texas Medicine* (pp 34–41). Time and time again, family physicians and other doctors take extra time to review lifestyle changes and preventive medicine, and to discuss age- and sex-appropriate screenings. As we all know, managed care does not increase our fees or the patient's co-pay, so it is somewhat frustrating for me to go the extra distance and then see this falsehood in print.

I think I can speak for most primary care physicians when I say that if we did every screening test and discussion, and the preventive medicine recommended by the so-called expert organizations (ACS, NIH, CDC, AMA, AAFP, ACP, etc, etc), we could probably see 5 or 6 patients a day. But I still try to keep my patients' needs first, despite financial pressure, managed care constraints, threats of lawsuits, and egregious government regulations.

Most of my colleagues and I still enjoy the medicine part of our profession by seeing and treating patients. I hope our patients and the media will appreciate us for that privilege.

Michael Lifshen, MD
2911 Medical Arts Square, Ste 14
Austin, TX 78705

I still try to keep my patients' needs first, despite financial pressure, managed care constraints, threats of lawsuits, and egregious government regulations.

Blue Cross and Blue Shield warning

Blue Cross and Blue Shield (BCBS) currently does not follow HCFA (Health Care Financing Administration) standard practices with respect to payment for evaluation and management (E&M) services provided at the same time as a surgical procedure (including nonoperative fracture care).

Under most insurance plans, E&M services provided on the same day as a surgical procedure are reimbursable if they are necessary to determine the appropriate type of treatment for the patient. This applies when a patient is seen for the first time for a given problem and must be evaluated before determining if a surgical procedure is indicated. This indication is designated by the placement of a -57 modifier on the appropriate level E&M code.

An example would be a 99202-57 (Expanded Office Visit) in conjunction with a 25605 (Closed Treatment of Colles' Fracture With Manipulation). Medicare and most payers recognize this modifier and pay for the E&M service in addition to the surgical procedure code.

Express your point of view in *Texas Medicine*. To submit a letter, mail, fax, or e-mail it to *Texas Medicine*, TMA, 401 W 15th St, Austin, TX 78701; fax (512) 370-1632; e-mail larry_b@texmed.org. Please type letters you submit for publication, and keep the length to 400 words or less. If necessary, you may include a few references, preferably less than five. Letters are published at the discretion of the managing editor and editorial advisors, and are subject to editing and abridgment. Letters represent the opinions of the authors and do not necessarily reflect the policies of the Texas Medical Association.

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Letters

BCBS and its medical director, Mark Clanton, MD, refuse to follow this industry standard and do not pay for E&M services necessary to determine the appropriate care for our patients.

Dr Clanton has stated in numerous discussions that he does not feel these services are worthy of compensation unless they are provided in the emergency department. Any non-emergency department E&M codes (including office visits, office or hospital consultations, and initial hospital care) are bundled (ie, not reimbursed) with the surgical code. The only E&M codes that BCBS allegedly will not bundle are Emergency Department Evaluations (99281-99285).

Dr Clanton has stated that I am the only physician who has complained about this practice and, therefore, he does not feel that it is worthy of reconsideration. However, according to the Texas Medical Association, numerous other physicians have complained to TMA about BCBS repeatedly denying these claims. TMA has a meeting planned with Dr Clanton and BCBS this fall to discuss several issues, including this policy.

Please contact Dr Clanton and TMA to voice your objections regarding this practice. Dr Clanton's office address is 1010 S Sherman, Ste 500, Richardson, TX 75081-4847. Send a copy of your letter to Teresa Devine, director of TMA's Health Care Financing Department, at 401 W 15th, Austin, TX 78701.

Dr Paul Handel is chair of the TMA Council on Socioeconomics, which is coordinating the meeting with BCBS. You may contact him through the same TMA address.

Unless we, as physicians, step up and make a case against this and other unfair policies by insurers, we will continue to see our practices eroded, as more payers jump on the bandwagon and deny payment for these and other necessary services.

William F. Tucker, Jr, MD
221 W Colorado Blvd
Pavilion One, Ste 200
Dallas, TX 75208

Dr Clanton responds

I would like to make two important points regarding payment of evaluation and management (E&M) services. First, as a private carrier, Blue Cross and Blue Shield of Texas (BCBS) is not required to follow HCFA guidelines to derive final payment policy. Second, the introductory section of the CPT manual states, "Inclusion or exclusion of a procedure does not imply any health insurance coverage or reimbursement policy." Consequently, the CPT manual does not compel coverage of a particular code or modifier; that decision is made by the health plan in question.

The E&M code does, however, reference evaluation of a new condition for the patient. This encounter could be in the provider's office or in the emergency department (ED). In either setting, the provider will determine an appropriate treatment, which may include surgical options such as the open or closed treatment of fractures.

Should the physician evaluate the patient in the ED as opposed to the office, we have made provisions for reimbursement of a consultation in addition to any surgical procedure claims submitted; the claims that arise in this setting are then paid manually. Office-based evaluations are considered part of a global surgical reimbursement or part of the standard office visit.

BCBS has discussed with the Texas Medical Association revisiting the addition of the modifier -57 when postmillennium system changes are possible within the BCBS system. While adding this modifier could change the manner in which the reimbursement is dispersed across codes, its addition is unlikely to change the overall reimbursement policy by procedure or diagnosis.

Physicians should address further questions to the BCBS provider service representative for their offices or areas.

Mark Clanton, MD, MPH
Chief Medical Officer and
Vice President, Health Care Management
Blue Cross and Blue Shield of Texas
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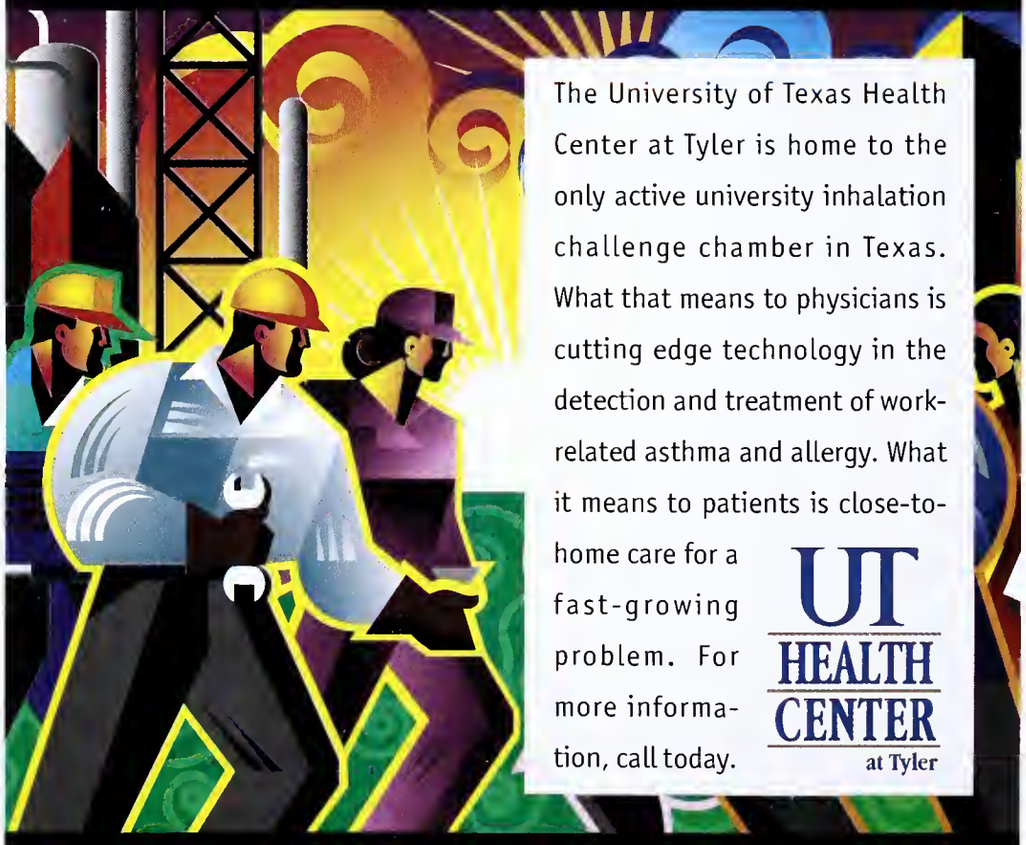

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Letters

Thanks, Texas

As I prepare to leave Texas, I am moved to write for several reasons: first, to express my thanks for the opportunity to work with the Texas Medical Association and its leadership to further the interests of academic medicine and medical education; second, to thank my colleagues for the considerations they have shown me; and third, to once again reinforce my belief that Texas, especially underserved areas of Texas, is the ideal place to conduct community-based education.

There are unique opportunities in this state to better serve the needs of Texans by providing their young people with an access to medical education, by providing opportunities for this education to take place in community-based settings, and for actively involving the practicing physicians in this process. Our experiences with the Nueces County Medical Society and other medical societies around the state suggest that the physicians of this state recognize their responsibility in serving these higher principles of access to education and health care for all.

I look forward to following the progress of the Coastal Bend Health Education Center and other community-based educational activities that the health science centers are beginning to engage in. I also look forward to participating with TMA and the Nueces County Medical Society in a seminar on community-based education this fall.

Once again, my thanks and best wishes to all of you. My only regret is that I didn't discover Texas earlier in my career.

Michael L. Friedland, MD
Interim Executive Vice President
for Academic Affairs
and Dean of Medicine
Texas A&M University
Health Science Center
College of Medicine
College Station, TX 77843

(Editor's Note: Dr Friedland is leaving Texas A&M to become the dean of medicine at the University of Missouri at Kansas City.)

Commentary

By Timothy Gorski, MD

I'm really getting tired of hearing that physicians are to blame for not resisting the corporatization of medicine and going along with the destruction of patient choice. Even now, there is a constant litany of those who preach that doctors shouldn't "allow" it to continue and should instead "take back" their profession. The latest example of this all-too-popular pabulum was offered by former US Surgeon General C. Everett Koop, MD, to the American Medical Association's Medical Student Section in June:

> . . . we have to return to professionalism. We were caught napping. If we had been the professionals we should have been, managed care would not have gotten the foothold it did, and we would not have as many managed care companies functioning for the benefit of stockholders instead of patients. . . . if you allow the business world to treat us like journeymen, then journeymen we will become (*American Medical News,* July 12, 1999, p 9).

I have the utmost respect for Dr Koop. Perhaps generic words of encouragement and inspiration like these are exactly what medical students need to hear. But although these statements — echoed almost daily by other medical leaders — appear to be factual, they simply do not reflect reality.

The future of American medicine depends on how some very serious questions are answered. These questions are implicit in the changes affecting us but seldom are they explicitly addressed or even recognized.

When, for example, did physicians abandon professionalism? When were we "caught napping"? What could physicians have done to forestall or eliminate the onslaught of "managed care" medicine? Just how are physicians supposed to refuse to "allow the business world to treat us like journeymen"?

Certainly, some physicians refused to sign contracts with the insurance companies when they came knocking with their alphabet soup "products" consisting of our own professional services, repackaged and trademarked. What happened to those physicians? Most are now enjoying their "professionalism" in retirement or wherever else they were forced to go when they had to close their practices. Even now, some physicians decline to participate in some health plans. As a consequence, their copying machines are their hardest-working employees, churning out copies of their patients' medical records to be sent to physicians who are "on the plan."

Other physicians who were "fortunate" to have medical problems of some kind claimed disability (sometimes going to work for insurance companies if their policies didn't reduce payments for such employment), which drove the cost of disability insurance for the rest of us to stratospheric levels. So much for putting patients before profits!

Would things have gone better if physicians had been more united in their resistance to these changes? Consider what happened to those who did. In cases where physicians maintained enough unity and determination to have a perceptible effect, they were punished for their efforts by antitrust laws and their enforcers. The only gain was in favor of the very forces the physicians opposed. Medical professionalism was ruled "collusion" and

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"restraint of trade." Its head was cut off and put on display as a lesson and a warning to others. This is what we're supposed to "return" to?

The simple fact is that physicians are victims of a great upheaval caused by widespread confusion and disagreement about what is and ought to be expected of the medical care system. Consumers, although they will gladly spend money on other unpleasantries from car repairs to toilet paper, generally believe that medical care should be low-cost or even free. But, and in part because it's not, consumers figure they are entitled to all the medical care they can get. Meanwhile, employers, who are footing the bills in most cases, see no reason to pay more than they have to for other people's — their employees' — medical care. Then, there are the ivory tower academics to whom medical care means numbers without the dollar signs: the number of children being vaccinated, rates of death from preventable diseases, and the proportion of people without health insurance or prescription drug benefits.

The future of American medicine depends on how some very serious questions are answered. These questions are implicit in the changes affecting us but seldom are they explicitly addressed or even recognized. When they are, they often create firestorms of controversy, so that the questions themselves, and their urgency, are lost beneath the belching smoke of slogans and catchwords such as "professionalism," "justice," "cost-effectiveness," and, of course, "restraint of trade." At the risk of stirring up such incendiary bombast, perhaps we ought to think coldly and dispassionately about these difficult — at least from the standpoint of achieving any measure of consensus — questions. They are interrelated. The questions could be phrased differently, but, in essence, they are:

- *What is medical care, anyway?* Considering everything medical science allows us to do, how much is really necessary to preserve life and health? How much goes more toward enhancing health and preventing diseases? Whose definitions of health and disease should be used? How many diseases are the result of, or at least contributed to by, personal behaviors?
- *How much should medical care cost?* When disease, death, and debility threaten, when they are pervasive and inescapable, people will pay any price for even the hope of escaping their worst effects. At other times, even after recovering from serious illness, people resent having to pay for medical care. They want to know that medical care is available if needed but are annoyed at its cost and complexity. Good health is a birthright, people are apt to think, and no one should have to pay for what they are entitled.
- *How much medical care is enough?* Here again, when threatened by illness and when hope for recovery seems less than assured, many people will endure endless medical and surgical treatments. To those who have no need of such interventions, treatment often appears to be a waste of money and resources. One person's last desperate chance is another's "futile care."

Indeed, anyone who supposes he or she knows the answers to these questions — and there are politicians, academics, and insurance company executives who are certain they do — ought to be viewed with considerable suspicion.

- *Do people have a right to medical care?* "Life, liberty, and the pursuit of happiness" come to mind when the subject of human rights is raised. But these amount essentially to the right to be left alone. If a fundamental right to medical care exists, it requires that others supply that medical care. But to what extent can this be accomplished? What are rights and responsibilities where medical care is concerned? And if medical care is a fundamental human right, should we not offer it, as we do "life, liberty, and the pursuit of happiness," to all who can manage to reach our country from other parts of the world?
- *Should people who neglect their health or refuse medical care be allowed to suffer the consequences?* America is called "a land of opportunity," but not everyone takes advantage of every opportunity. Some people, despite knowing the risks, use tobacco, drink alcohol, abuse drugs, engage in high-risk sports or occupations, do not get immunizations and other routine prevention measures, or go without health insurance. When people lose these gambles, is it the responsibility of others to save them from the consequences of their own actions? Or is it the responsibility of other people to do whatever is necessary — up to and including paying people to reduce their risks and submit to preventive medical care? Should it make a difference whether the cost of caring for advanced disease is more or less than preventing it or diagnosing it in its early stages? Regardless of how we answer these questions, how far should such thinking be applied? Even preventive medical care does not guarantee good health and can result in complications or unnecessary additional testing and procedures. These issues become especially thorny when children are involved.
- *Who should pay for medical care?* Should people pay for the medical care they want and need? Or should they be entitled to what they need

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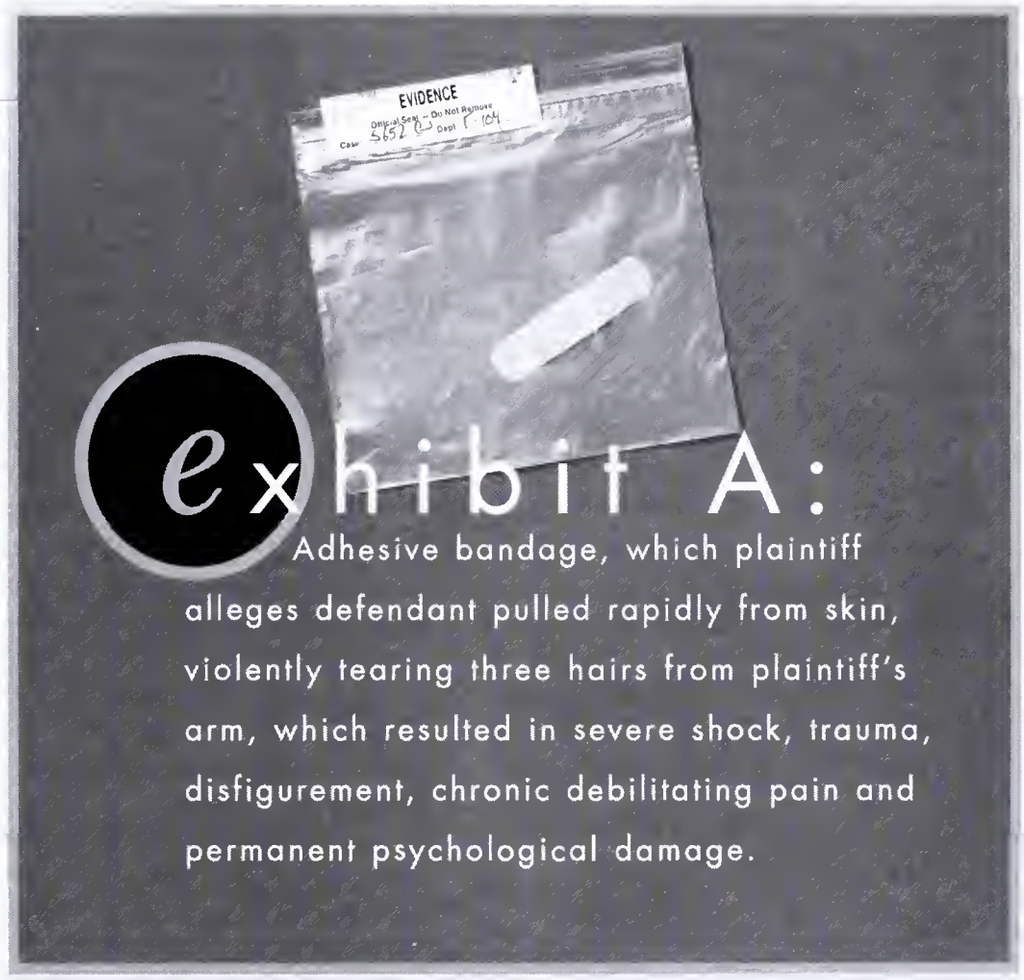

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and pay only for what they want, assuming it is possible to tell the difference? If people are entitled to what they need without having to pay for it, who should pay? Should everyone be forced to pay through taxation? What if "medically unnecessary" care uncovers conditions or results in complications that require additional care? How should that be classified? Or, alternatively, should a distinction be made between routine and expected preventive medical care and unexpected, catastrophic needs?

- *Who should "provide" medical care?* Is it necessary to have a single, rigid standard of medical care that can only be supplied by trained physicians? If the physical and financial resources to provide the highest standard of medical care for everyone do not exist, is it better that some people receive a lower standard of care from nonphysician professionals or even from self-taught but otherwise untrained individuals? Should people be allowed to seek such a lower standard if they think it is a better value for their money or if, perhaps, the nonstandard practitioners are able to persuade them that they offer just as good or even better care than trained physicians?

There is no reason to think that physicians or any other medical professionals have the best answers to these questions. Indeed, anyone who supposes he or she knows the answers to these questions — and there are politicians, academics, and insurance company executives who are certain they do — ought to be viewed with considerable suspicion. But physicians and others intimately involved with the medical care of patients have a better appreciation and understanding of the issues and are in a better position to explain and illustrate them with real-world experiences instead of figures and bar graphs. People need to consider these questions as if their lives depend on them because they very well might. There are no simple solutions, least of all throwing up our collective arms and letting politicians make the decisions.

How can a serious public discussion of this kind come about? Is serious public discussion possible in an era of mass media manipulation, biased polls, million-dollar ad campaigns, and spin-doctoring? It would be helpful if those who fault physicians for having been "caught napping" and call on them not to "allow the business world" to manipulate the heart and soul of medicine would take time to call the general public's attention to what is happening.

It is not physicians who were "caught napping" or who "allow the business world" to do as it pleases with them and their patients. It has been Americans in general who have been largely oblivious to the wrenching changes in medicine. If physicians are guilty of anything, it is a reluctance to sound the alarm. Perhaps we felt embarrassed about Medicare's having taken a little longer than we expected to show its serious faults. Or perhaps we were afraid of being labeled — as we have been — as nothing but a self-interested elite. Or perhaps we thought that people would never sympathize with highly educated professionals who are among the top 1% of income earners.

Whatever the reason, the time has come for knowledgeable, articulate, and recognized medical professionals to speak out on the realities of modern medicine. The old maudlin slogans have been run into the ground. It is time for a tougher and more realistic coming to terms with the way things really are and the directions in which they are running. It is time for the truth. ★

Dr Gorski is an obstetrician-gynecologist in Arlington. He is a member of the Publications Committee of the Tarrant County Medical Society.

People

Newsmakers

Joseph S. Bailes, MD, of Dallas, was elected president of the American Society of Clinical Oncology (ASCO). Dr Bailes has been active in ASCO activities since its inception, including spearheading creation of the State/Regional Affiliates Program to enhance participation within all facets of the society. He also has worked to ensure access to high-quality oncologic care, including negotiating issues ranging from coverage of patient care costs associated with clinical trials to physician payment reform to off-label uses of antineoplastic drugs.

H. Randolph Bailey, MD, of Houston, is the new president of the American Society of Colon and Rectal Surgeons.

Mark A. Baker, DO, is the president of the Texas Osteopathic Medical Association District II for 1999–2000. Dr Baker is chair and clinical associate professor of radiology at the Texas College of Osteopathic Medicine at the University of North Texas Health Sciences Center in Fort Worth.

His efforts to increase organ donor awareness, which resulted in the Texas Medical Association Live & Then Give campaign, has won **Phil H. Berry, Jr, MD,** former TMA president, of Dallas,

Joseph S. Bailes, MD

Phil H. Berry, Jr, MD

the Burl Osborne Pioneer Hero Award from the International Society for Artificial Organs. Dr Berry and his wife flew to Scotland to accept the award in August.

The Alamo Area Emergency Physicians organization in San Antonio has elected **Ann J. Burgardt, MD,** as president. The group examines emergency medical care in the Bexar County area. Dr Burgardt is assistant professor of emergency medical technology at The University of Texas Health Science Center at San Antonio and assistant medical director for the San Antonio Fire Department Emergency Medical Services.

D. Clifford Burross, MD, of Wichita Falls, is the new president of the Texas Medical Foundation Board of Trustees. Dr Burross, who will serve a 2-year term, is director of the Wichita Falls Family Practice Residency Program, which is associated with The University

D. Clifford Burross, MD

Donald J. Gordon, MD, PhD

John W. Meyer, MD

Jack Weinblatt, MD

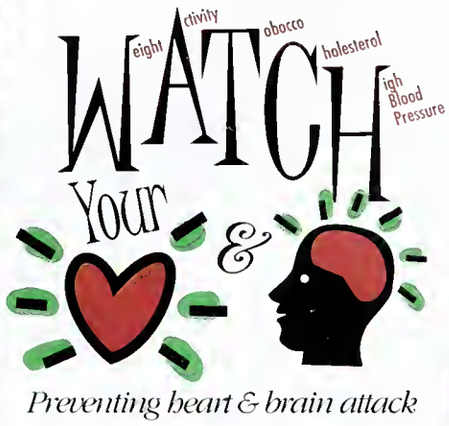
of Texas Southwestern Medical Center at Dallas. He is a former TMA president.

A desire to help people who need medical care but can't afford it has earned **Nathan Cedars, MD,** of Stephenville, the Governor's Volunteer Award in the senior citizen category. Dr Cedars, 82, established the HOPE medical clinic in 1991 and enlisted the aid of other physicians and health professionals, as well as financial assistance from the business community.

TMA student member **Adriena Cothron** is 1 of only 26 medical students in the United States to be selected for a place in the Fellowship Program in Academic Medicine. She is

Please let *Texas Medicine* know about your honors and achievements. Criteria for inclusion in the Newsmakers section are TMA membership; election or appointment to an office of, or honors from, a national or state organization; or, space permitting, recognition at the local level. Items for the Newsmakers section are published at the discretion of the managing editor. Submit items for consideration, with photos if possible, to People, *Texas Medicine*, 401 W 15th St, Austin, TX 78701; fax (512) 370-1632; e-mail larry_b@texmed.org.

PROJECT WATCH



Project WATCH, a new cardiovascular disease and stroke prevention education program, aims to knock the No. 1 and No. 3 killers of Texans off the charts.

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People

a student at the Texas College of Osteopathic Medicine at the University of North Texas Health Sciences Center in Fort Worth. Ms Cothron spent 12 weeks examining the role of otoliths in vestibular function in orthostatic stress.

James R. Cullington, MD, of Austin, is the new president of the Texas Society of Plastic Surgeons.

David E. Fixler, MD, professor of pediatrics at The University of Texas Southwestern Medical Center, was appointed the first holder of the newly upgraded Fred S. Brooksaler Professorship in Pediatrics. Dr Fixler is director of pediatric cardiology at Children's Medical Center of Dallas. The professorship is named in honor of the late Dr Brooksaler who fled Nazi persecution in Germany in 1938 and established a successful practice in America. He was the first director of the birth defects center at Children's Medical Center.

Herbert L. Fred, MD, and **Larry D. Scott, MD,** both of Houston, received the Benji F. Brooks, MD Outstanding Clinical Faculty Award from The University of Texas-Houston Medical School.

The American Heart Association, Texas Affiliate, named **Donald J. Gordon, MD, PhD,** of San Antonio, the 1999 recipient of the Outstanding Stroke Volunteer Award. Dr Gordon, department chair for emergency medical technology at The University of Texas Health Science Center at San Antonio, has volunteered his time and service to the association since 1996. He helped develop a pilot Metro Stroke Task Force in San Antonio, and under his leadership, the program proved so successful it is serving as the model for the heart association's national "Operation Stroke" program.

John W. Meyer, MD, of Hondo, received the Philip R. Overton Award from the Texas Medical Foundation (TMF). The annual award, named for TMF's legal counsel for 10 years, is presented to physicians who provide meritorious service in peer review. Dr Meyer recently completed his second 2-year

term as president of the TMF Board of Trustees. He is the acting director of the Medina County Health Unit.

William Patrick Moore, MD, of Houston, will receive the Distinguished Service Award from the Texas Society of Psychiatric Physicians at its annual meeting in San Antonio next month.

Barry Roberts, MD, of Nacogdoches, received the Community Preceptor Excellence in Education Award from the Department of Pediatrics at The University of Texas Medical Branch (UTMB) at Galveston. Dr Roberts has taught 27 medical students since he was appointed associate professor of pediatrics at UTMB.

William E. Sponsel, MD, is the winner of the American Academy of Ophthalmology 1999 Achievement Award. He is associate professor of ophthalmology at The University of Texas Health Science Center at San Antonio.

Alan Stockard, DO, has been elected second vice president of the Board of Directors of the American Osteopathic Academy of Sports Medicine. He is chief of sports medicine and associate professor of family medicine at the Texas College of Osteopathic Medicine at the University of North Texas Health Sciences Center in Fort Worth.

The VistaCare Foundation has honored **Jack Weinblatt, MD,** of Temple, with its Central Texas Physician of the Year Award. Dr Weinblatt was cited for his compassion and effectiveness in helping patients and their families at the VistaCare Family Hospice in Temple.

Deaths

Overton Owen Antony, MD, 87; Humble; Louisiana State University School of Medicine, 1937; died July 9, 1999.

Melford Sherman Dickerson, MD, 87; Canyon Lake; Baylor College of Medicine-Dallas, 1939; died July 22, 1999.

RFS

Residents, mark your daytimers!

THE NEXT MEETING OF TMA RESIDENT & FELLOW SECTION *(formerly known as the Resident Physician Section)* WILL BE:

Friday, November 12, 8-10 p.m.
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People

Ward George Dixon, MD, 78; Tyler; Marquette University School of Medicine, 1948: died May 2, 1999.

Saul Grossman, MD, 88; Corpus Christi; The University of Texas Medical Branch at Galveston, 1935; died August 1, 1999.

Oscar Gaza Janes, MD, 79, Cooper; Baylor College of Medicine, 1947; died July 25, 1999.

Ben Lee Johnson, MD, 60; Athens; The University of Texas Southwestern Medical School at Dallas, 1963: died May 2, 1999.

Luis Leib, MD, 67; Dallas; The University of Texas Southwestern Medical School at Dallas, 1957; died August 7, 1999.

Ramesh Daji Limaye, MD, 64; San Antonio; B.J. Medical College-India, 1958; died July 5, 1999.

Leland Corbette Long, DO, 71; Concan; Kirksville College of Osteopathic Medicine, 1956; died March 13, 1999.

William Francis MacDonald, MD, 76; El Paso; Tufts University School of Medicine, 1946; died February 10, 1999.

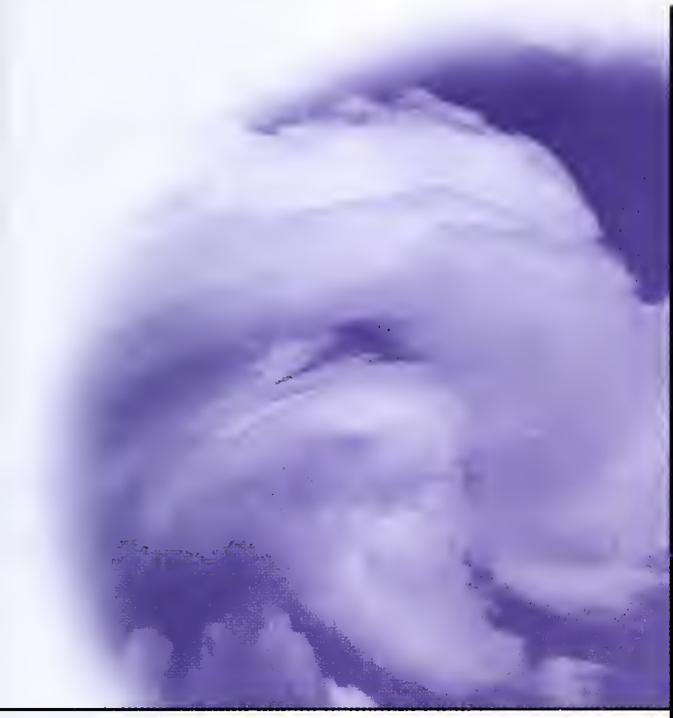
Milad N. Milad, MD, 44; Wichita Falls; Ain Shams University School of Medicine-Egypt, 1979; died July 25, 1999.

David Brett Mitchell, MD, 41; Denison; The University of Texas Southwestern Medical School at Dallas, 1984; died July 21,1999.

Carolyn Zuch Rheiner, MD, 40: Dallas; The University of Texas Southwestern Medical School at Dallas, 1985; died July 4, 1999.

Henry E. Wahlen, MD, 83; Houston; Marquette University School of Medicine, 1948; died March 27, 1999.

John Elmer Wiedeman, MD, 91; Dallas; The University of Texas Medical Branch at Galveston, 1933; died July 20, 1999.



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Texas Medicine Rounds

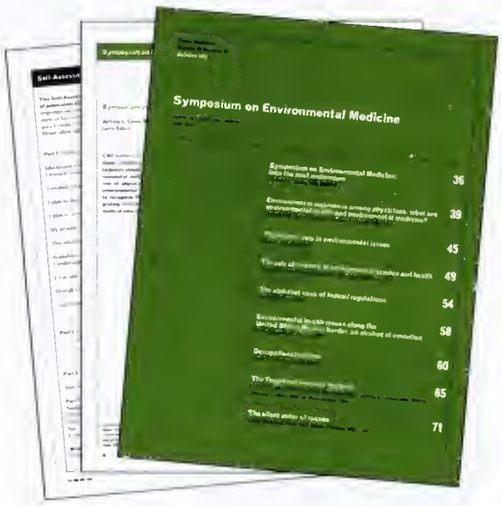
Texas Medicine offers CME credit for reading October articles

This issue of *Texas Medicine* is a landmark in the magazine's 95-year history. For the first time, physicians can earn continuing medical education (CME) credit by reading articles in the magazine, making *Texas Medicine* the first state medical society journal to offer CME credit.

Physicians who read the articles on environmental medicine, complete the evaluation form on page 77, and return it to *Texas Medicine* within the next year will be eligible for 2 hours of Category 1 credit toward the American Medical Association Physician's Recognition Award. A certificate awarding the CME credit will be sent by fax or mail within 4 weeks.

This issue was approved for CME credit by the Texas Medical Association Committee on Continuing Medical Education as part of the association's overall CME program.

Environmental medicine was selected as the topic for the 1999 symposium issue by the magazine's Editorial Committee, a group of physicians appointed by the TMA Board of Trustees to set broad policies for the publication, at its February 1998 meeting. Committee members discussed the growing interest in environmental medicine, the impact of the environment on patients in Texas, and the lack of published information about the topic. Jeffrey L. Levin, MD, PhD, professor and chair of the Department of Occupational and Environmental Medicine at The University of Texas Health Center at Tyler, is the guest editor.



"*Texas Medicine* recognizes the importance of continuing medical education, not just as a requirement for licensure but as an integral part of the practice of medicine," said John C. Jennings, MD, Editorial Committee chair. "The symposium issues of our journal target topics that are particularly applicable to the practice of Texas physicians. By offering CME credit for these issues, we hope to encourage critical examination of areas that are important to a majority of our readership, while simultaneously making it easy to obtain CME." ★

POEP

POEP offers free kits for tobacco counseling

As Bob Dole used to say on the campaign trail, "I know it, you know it, and the American people know it." In this case, "it" is that tobacco is bad for you and tobacco use is the single largest preventable cause of death and disability. Yet the whirlwind pace of today's medical practice often makes it difficult for many physicians and their patients to discuss tobacco use during regular office visits.

To overcome this, the Physician Oncology Education Program (POEP) has joined Blue Cross and Blue Shield of Texas, the Texas Department of Health (TDH), and others key to the fight against tobacco-related disease and death to create the Tobacco-Free Texas Tool Kit for clinical offices.

The kit, available free from POEP, helps physicians and other clinicians address tobacco use, prevention, and cessation with patients of all ages. And, technical assistance for making counseling on the risk of tobacco use part of an office-wide approach is available from TDH's Put Prevention into Practice initiative.

POEP is funded by the Texas Cancer Council. For more information on how to receive a kit and/or technical assistance, call POEP at (800) 880-1300, ext 1672, or (512) 370-1672; or e-mail poep@texmed.org. ★

Stress program offers help to frazzled physicians

Had it with practicing medicine? Drinking too much? Can't sleep? Often lose your temper with colleagues and family members? Find it difficult to deal with your patients and make decisions? Wish you'd been a farmer? Wonder if drugs will make it all better?

Before it's too late, check out "Beyond Survival: Techniques to Reduce Stress," offered by the Texas Medical Association Committee on Physician Health and Rehabilitation October 30 at the Wyndham Garden Hotel in the Dallas Market Center.

The seminar is designed for physicians, hospital administrators, nurses, pharmacists, dentists, dietitians, psychologists, nurse anesthetists, attorneys, licensed professional counselors, social workers, podiatrists, other health care professionals, and their spouses.

The program is designated for up to 6.5 hours in Category 1 credit toward the American Medical Association Physician's Recognition Award. TMA also has designated these hours as ethics/professional responsibility education.

Participants completing the course should be able to discuss impairment's impact on health care professionals and others, distinguish what can be done to help professionals in recovery, and recognize the ethical dilemmas when considering whether to report a colleague for suspected impairment. They also should be able to refer colleagues to appropriate resources for help, assess their profession's peer assistance program, evaluate the three stages of burnout to determine their own stress level, apply learned skills to manage stress, identify sources of assistance for unmanaged stress, and explain survival skills for family stress.

The advance registration fee is $65, which includes continental breakfast, lunch, breaks, and seminar materials. For a brochure, contact Linda Kuhn, TMA, 401 W 15th St, Austin, TX 78701-1680; call (800) 880-1300, ext 1342, or (512) 370-1342; or e-mail linda_k@texmed.org.

Five of the courses designed by the Committee on Physician Health and Rehabilitation also are available for continuing medical education credit in the "Members Only" section of the TMA Web site at www.texmed.org. ★

Synthroid makers settle lawsuit over claims

Texas and 36 other states have settled their lawsuits against Knoll Pharmaceutical Company, the maker of Synthroid, over charges that it wrongfully claimed the synthetic thyroid hormone drug was superior to competing brands. Although it did not admit any wrongdoing, Knoll agreed to pay $41.8 million to settle the case. Spokeswoman Linda Mayer told the Associated Press the company wanted to "avoid the burden and expense of litigation."

Attorneys general from Texas and the other states alleged that Knoll violated consumer protection laws by claiming that Synthroid was unique or superior to competing brands.

They also said Knoll attempted to prevent the publication of a study that showed Synthroid was no more effective than some generic thyroid drugs. The other drugs are two to three times less expensive than Synthroid.

A class action suit involving consumers is pending. ★

Screening of pregnant women for hepatitis B now required

State law now requires pregnant women to be screened for hepatitis B virus (HBV) infection during the first prenatal examination and at delivery. The law, which took effect September 1, applies to physicians and others who attend pregnant women during gestation or at delivery. It amends previous legislation that required only the testing of pregnant women for syphilis and HIV infection.

Although testing pregnant women for hepatitis B is considered the standard practice of care, it has not been a legal requirement until now.

A Texas Department of Health (TDH) news release says 90% of infants infected with HBV perinatally will become chronic carriers of the virus, but 97% of these infections can be prevented with appropriate immunotherapy. Within 12 hours of birth, 0.5 mL hepatitis B immune globulin and 0.5 mL of hepatitis B vaccine (dose 1) should be administered. Doses 2 and 3 of the hepatitis B vaccine can be administered to the infants at ages 1 and 6 months, respectively (or dose 2 can be administered at the 2-month visit, along with other vaccines).

For more information, contact the TDH Immunization Division in Austin at (800) 252-9152 or (512) 458-7284.

Also, hospitals are now permitted to test patients for hepatitis B or C without their consent when health care workers have been exposed accidentally to patients' blood or body fluids. Hospitals are required to notify patients and health care workers of the test results. ★

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Primary care doctors getting fewer job offers

If you're thinking about a career as a primary care physician, listen up. A survey of 300 residents by a Dallas-based national physician recruiting firm shows that primary care doctors completing training this year are receiving fewer job offers than in the past. The Merritt, Hawkins & Associates survey, reported by the *Nashville Medical News*, indicates that medical students' stampede to careers in primary medicine may be about to be headed off at the pass.

According to the survey, almost a quarter of US-trained primary care residents received 10 or fewer job offers in 1999, compared with the 11% who received 10 or fewer job offers in 1995. Meanwhile, only 6% of residents received 100 or more job solicitations, compared with 17% receiving 100 or more in 1995.

The *Medical News* cited another survey by a national staffing firm, Staff Care, that indicates that specialists are more in demand. In the temporary physician market, radiologists, psychiatrists, anesthesiologists, and all internal medicine subspecialists are in high demand, Staff Care reported.

Joe Smith, vice president at Merritt, Hawkins & Associates, told the *Medical News* that health care reform in the early 1990s inspired many medical students to seek primary care residencies. The expectation was that demand for specialists would dry up under any kind of reform. While the demand for primary care doctors skyrocketed as expected as managed care companies emphasized the gatekeeper, he says, that has leveled off, and the demand for specialists did not shrink as anticipated. In fact, Mr Smith says the strong economy has resulted in a shortage of specialists in the market today.

The *Medical News* says major markets on both coasts have limited openings for primary care physicians, but multiple openings are available in the Southeast, Midwest, and Southwest. Even in these areas, however, the "feeding frenzy is over," Joseph Hawkins, chief executive officer of Merritt, Hawkins & Associates, told the publication.

The Merritt, Hawkins & Associates survey of residents also shows that:

- More than half say they prefer not to work in a managed care environment, a 21% increase from 2 years ago.
- More than 75% say they prefer to establish their practices in towns of 75,000 or larger.
- Eleven percent say they would not choose medicine if they were starting over. That's more than twice the percentage of residents who were dissatisfied with medicine in 1997. ★

Youth violence drops, but gunfire is still expensive

Violent acts committed by teenagers declined between 1991 and 1997, the *Journal of the American Medical Association (JAMA)* reported in August, but there's no cause to celebrate because researchers say the rates of youth homicide and other violence remain at "historically high levels."

According to the *JAMA* study, the number of students who say they got into fights or carried weapons dropped significantly. In 1991, 42.5% of high school students said they had been in a fight, and 26.1% said they had carried a weapon. But in 1997, those figures dropped to 36.6% and 18.3%, respectively.

The study was based on data collected by the Youth Risk Behavior Survey of the Centers for Disease Control and Prevention.

JAMA also reported that, assuming an average cost of about $17,000 per gun injury, the lifetime cost of gunshot wounds in the United States in 1994 was $2.3 billion. The government funded about 49%, or $1.1 billion, of these costs, researchers said. Private insurance paid for about 18% of the costs, and the rest came from other sources.

Gunshots were to blame for 31,636 deaths and about 100,000 nonfatal injuries in the United States in 1997, the report said. ★

WEB SITES OF INTEREST TO TEXAS PHYSICIANS

MedBytes

It seems as though new medical Web sites on the Internet are going online almost daily. Here are a few Texas sites worth checking out.

Stomping out viruses

Computer virus got you down? The Dallas Virus Response Team (DVRT) can help. Visit www.virusMD.com for help on computer viruses or Y2K bug concerns. DVRT is made up of Texas physicians and engineers interested in fighting computer viruses. The information is free, including tutorials geared to both computer newcomers and advanced users, says Cyrus Peikari, MD, a member of DVRT and the TMA Web site Virtual Advisory Committee.

Free online journals

Drop by www.ispub.com where free electronic medical journals are available to readers. The site is operated by Olivier C. Wenker, MD, associate professor of anesthesiology and critical care at The University of Texas M.D. Anderson Cancer Center. Visitors to the site can obtain free subscriptions to peer-reviewed journals, including *Clinical Oncology, Emergency and Intensive Care Medicine, Family Practice, Internal Medicine,* and *Surgery. The Internet Journal of Anesthesiology*, for example, publishes original articles, case reports, reviews, letters to the editor, multimedia slide shows, and videos.

Internal Medicine Board Review course

The University of Texas-Houston Medical School and VistaLink Medical Communications have launched a free online Internal Medicine Board Review course at www.vistalink.com. The course can be accessed by completing the free registration form on the VistaLink home page. It consists of lectures presented by physicians at UT-Houston and The University of Texas M.D. Anderson Cancer Center on topics ranging from cardiology to endocrinology. The VistaLink site offers more than 50 lectures, many of which are in English and Spanish, says Guillermo Gutierrez, MD, PhD, VistaLink president.

Boning up on osteoporosis

The Scott & White Division of Endocrinology and Merck Pharmaceutical have created an interactive Web site at www.sw.org/ed/osteo to educate patients on osteoporosis. The site includes examples of DEXA scans and information on understanding what the numbers mean. Each section contains links to more resources and information. Patients who do not require hands-on therapy can e-mail questions. The site is not designed to replace the physician, nurse, or health educator, but expands resources now available to patients, says Veronica K. Piziak, MD, PhD, director of Scott & White's Division of Endocrinology and a codeveloper of the site.

Online ethics

More than 900 physicians have taken advantage of the TMA Library's continuing medical education module "Medical Ethics and Professionalism." Written by Julie Graves Moy, MD, Austin, the program is available on the TMA Web site at www.texmed.org (click on "Education/CME" and then "Continuing Medical Education"). TMA is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education (CME) for physicians. TMA designates this CME activity for 1 hour in ethics education. It costs $10 for TMA or Texas Osteopathic Medical Association members and $15 for nonmembers. For more information, call the TMA Library at (800) 880-1300, ext 1542, or (512) 370-1542; or e-mail tmalibrary@texmed.org.

MedBytes is a quick look at new, or newly discovered, Web sites of interest to Texas physicians. The column also highlights features of the TMA Web site at www.texmed.org. If you know of some cool medical sites or have questions about how to use the TMA Web site, e-mail larry_b@texmed.org. Publication of information about Web sites in this column is not to be considered an endorsement or approval by the Texas Medical Association of the sites or sponsors, or of any products or services involved.

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Genesis files for Chapter 11 protection

Genesis Physicians Practice Association (GPPA) in Dallas, a 5.01(a) entity whose battle with Aetna US Healthcare was a factor in passage of the Physician Negotiation Bill by the Texas Legislature last spring, has filed for reorganization protection under the US Bankruptcy Code. The decision followed weeks of analysis of claims payment and insurance company reimbursement problems, officials say.

"GPPA made a noble effort to maintain the quality of patient care that our doctors feel is necessary for health care excellence," said Ralph Turner, MD, GPPA chair. "Unfortunately, our situation is similar to that faced by doctor groups in HMO capitated risk contracts across the nation. The deciding factor that led to the filing was in claims processing: slow bill processing and backlogs of claims made it impossible for us to gauge — and manage — overutilization of, or overpayment for, services. The results were unsustainable losses and the need to reorganize."

GPPA's action will affect seven HMO risk contracts covering about 30,000 patients. GPPA will renegotiate the HMO contracts with the goal of keeping its current physicians and maintaining quality care, Dr Turner says. The group's point-of-service and preferred provider organization contracts are not affected.

GPPA made news last year when it decided to terminate its contract with Aetna amid a dispute over what the physicians viewed as Aetna's failure to comply with their contracts and provide information that was critical to physicians' management of patient care. Aetna then threatened legal action for alleged antitrust law violations. (See "Antitrust Hammer," February 1999 *Texas Medicine*, pp 48–50.)

In May, the Texas Legislature passed Senate Bill 1468, which does not exempt physicians from federal antirust law but provides a defense against antitrust allegations by having the state supervise any joint negotiations between independent physicians and a health plan. (See "Antitrust Defense," August 1999 *Texas Medicine*, pp 28–32.) ★

WHAT YOUR PATIENTS ARE READING

Dateline: Health

By Laura Albrecht

The following is a collection of current consumer magazine articles that feature health and medical information that your patients may read and ask you about. Send your suggestions and comments to Laura Albrecht, *Texas Medicine*, 401 W 15th St, Austin, TX 78701; or e-mail laura_a@texmed.org.

"ER DIARY." A New York City emergency room doctor takes readers on a minute-by-minute tour of a patient having a heart attack. *Talk*, 9/99

"HIP TO THE BONE." Take an in-depth look at the ever-so-faithful hip, and learn some simple routines that will keep the hip in tip-top shape. *Outside*, 9/99

"THE DOCTOR IS OUT." Would you leave the comfort of your hometown practice to face savage conditions to treat cholera and perform amputations in the Third World? *UTNE Reader*, 9/99

"THE PERFECT PILL." The little wonder drug — aspirin — blocks the ill winds of Alzheimer's disease, arthritis, cancer, flu, gallstones, headaches, heart attack, and stroke. *Men's Journal*, 9/99

"TOO MUCH PRIVACY IS A HEALTH HAZARD." More concerns are expressed about the privacy of medical records — this time, it's about doctors not having access to patients' records. *Newsweek*, 8/16/99

"WHEN MANAGED CARE MEANS MEDICARE CARE." Another medical horror tale about the patient versus the HMO beast is told. *Newsweek*, 8/16/99

"PASSION PILL." Science is creating sex on demand. *Discover*, 9/99

"ON THE EDGE OF SILENCE." A woman struggles to regain her hearing. *Good Housekeeping*, 9/99

"MEDICAID'S BIG TIME RIP-OFF." How are tax dollars wasted in nursing homes, hospitals, and clinics? *Reader's Digest*, 8/99

"SEX & BODY." Young, inquiring minds want to know about bed wetting, excessive bleeding during periods, pregnancies, and white teeth. *Seventeen*, 9/99

"ARE YOU LOSING BONE?" Bone loss is not a concern just for the elderly. Learn timely tips for healthy bones. *New Age*, 9/10/99

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- CHIP

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- Fulfills the Texas State Board of Medical Examiners' one-hour ethics requirement
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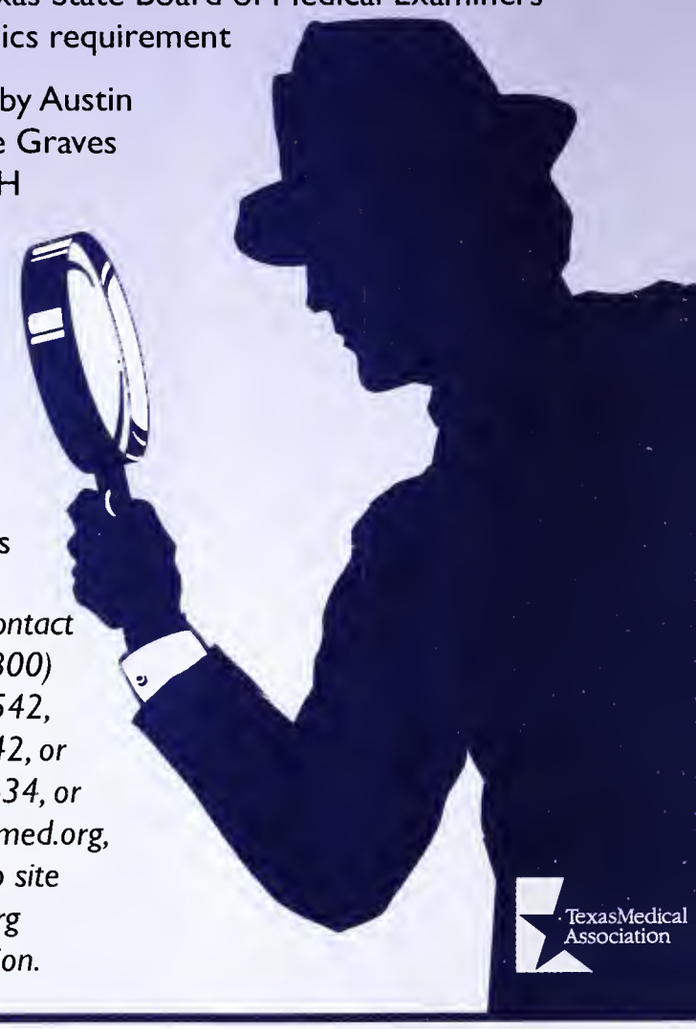
- Costs $10 for TMA members and TOMA members (as of 8/1/99) and $15 for non-members



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TexasMedical Association

Viagra can affect eyes, arthritis drug more popular

It looks like Viagra affects more than one part of the body. The September/October issue of *Survey of Ophthalmology* says that while potential ocular risks of the popular anti-impotence drug have been recognized, researchers do not know as much as they should.

Based on their own research and a survey of the current literature, Drs Michael E. Marmor and Robert Kessler of Stanford University School of Medicine conclude that caution and further study are warranted. They cite studies showing Viagra's direct effect on the chemistry of the retina by inhibiting an enzyme in the photoreceptors, and documented cases of mild changes in retinal electrical activity within a few hours of taking the drug.

The physicians say the established link between Viagra and visual function clearly indicates a need for more long-term research and the possible monitoring of patients with existing eye conditions. They also urge physicians to advise their patients of possible visual disturbances and to urge reasonable caution while driving.

Meanwhile, an arthritis pain relief drug has surpassed Viagra to become the fastest selling new drug ever. The drug, Celebrex, offers arthritis pain relief with less stomach irritation.

According to IMS Health, a research company, Celebrex, which was introduced in January, sold 6.86 million prescriptions in its first 6 months on the market. Prescriptions for Viagra totaled 6.05 million in the first 6 months after its introduction.

While the preference of Celebrex over Viagra may be a reflection of the changing priorities of an aging Baby Boom generation, the market advantages of Celebrex over Viagra are obvious. Both men and women suffer from arthritis, while Viagra is for men only. ★

SUMMARIES OF RECENT HEALTH CARE FINDINGS

In Case You Missed It

By Jennifer Ownby

The American Academy of Pediatrics has endorsed the US Public Health Service recommendation that women capable of becoming pregnant consume at least 400 mcg of folic acid daily at least a month prior to conception and throughout the first trimester of pregnancy to prevent neural tube defects. *Pediatrics*, 8/99

People using stronger sunscreens don't feel the effects of sunburn as quickly and spend more time outside, which increases their risk of skin cancer, according to a study that finds even the best prevention isn't foolproof. The European researchers concluded that "sunscreens may encourage prolonged sun exposure because they delay sunburn." *Journal of the National Cancer Institute*, 8/4/99

For the first time, female gender has been shown to be an independent risk factor for stroke after cardiac surgery. *Circulation*, 8/10/99

Neoadjuvant chemotherapy appears to be effective in eradicating breast cancer axillary lymph node metastases prior to surgery. *Annals of Surgery*, 7/99

Scientists have successfully generated viable infectious influenza A virus entirely from cloned complementary DNA in a new reverse-genetics system. *Proceedings of the National Academy of Sciences*, 8/3/99

The effect of androgens in stimulating prostate cancer cell proliferation is lessened by antioxidant vitamins. *Journal of the National Cancer Institute*, 8/21/99

The benefit of using antibiotics to treat acute bronchitis in otherwise healthy patients is not great enough to justify antibiotic use in this patient population. *American Journal of Medicine*, 8/99

Children with a genetic predisposition to produce high concentrations of a blood-clotting enzyme linked to meningitis are twice as likely to die from the severe form of that disease as other children, new research says. *The Lancet*, 8/99

Exposure to secondhand cigarette smoke makes nonsmokers 82% more likely to have a stroke, indicating that the dangers of "passive smoking" are worse than first thought, researchers in New Zealand report. *Tobacco Control*, 8/99

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TexasMedical Association

Fatal job accidents increase in Texas

It's getting more dangerous to go to work, especially if you are a self-employed, middle-aged Hispanic woman who drives on the job. A sobering report from the Texas Workers' Compensation Commission (TWCC) shows that fatal injuries on the job in Texas increased by 14%, from 459 in 1997 to 523 in 1998.

As usual, transportation accidents accounted for the most deaths. The 213 fatal accidents represented 41% of the lethal job-related incidents.

Worker groups most affected by the increased number of job fatalities included the self-employed, with a 32% increase, followed by Hispanics (31%) and workers over age 55 (19%). The deaths of 46 women in work-related injuries were the highest ever recorded in Texas, the TWCC report says.

The only good news, says TWCC Executive Director Len Riley, is that the number of fatalities in agriculture and of workers hit by motor vehicles and moving objects declined. ★

Pharmacy benefit costs show large increase

Insurance coverage for drugs increased nearly 17% last year, according to a report compiled by Express Scripts, a pharmacy benefit firm. This increase in pharmacy benefit costs is the largest growth rate of any year tracked by Express Scripts since 1993.

The company's 1998 Drug Trend Report says overall health care expenditures slowed throughout the decade, but drug costs rose, from a 7.9% growth between 1993 and 1994 to 13.4% between 1996 and 1997 and 16.8% last year, according to a June 30 *Reuters Health* report. Express Scripts expects the trend to continue with increases of 13% to 17% over the next several years.

Express Scripts officials used the company's database of 7.2 million managed care and non-managed care members in 1997 and 8.8 million members in 1998 to compile the report. ★

Researchers looking for a comfortable pair of genes

Houston's Baylor College of Medicine, Methodist Hospital, and Texas Children's Hospital have teamed up to create what they say is the most comprehensive center for the research and clinical use of cell and gene therapy in the world.

The *Houston Business Journal* reports the International Center for Cell and Gene Therapy initially will continue to focus on gene therapy's role in the treatment of certain cancers but will branch out to develop AIDS protocols. Within the next decade, neurological disorders, such as multiple sclerosis, and cardiovascular illnesses could be treated with the therapy.

Although not the first research and treatment center for this type of therapy, the Houston operation is the first in the world to combine basic science and clinical research and adult and pediatric transplant units, the *Business Journal* says.

The center will start with a staff of 20 clinical and research faculty and add 30 additional researchers and 300 support staff over the next 5 years. ★

M.D. Anderson to join cancer information program

The University of Texas M.D. Anderson Cancer Center in Houston is 1 of 14 US institutions selected by the National Cancer Institute to take part in a revamped program to provide accurate cancer information to the public.

Beginning October 15, the outreach component of the Cancer Information Service (CIS) will be renamed the CIS Partnership Program. Its new priorities will be education on breast and cervical cancer, clinical trials, tobacco control, and general cancer awareness for special populations.

Created in 1976, CIS provides up-to-date scientific information, assists organizations in developing educational efforts to reach people who do not have easy access to cancer information and services, and studies ways to promote healthy behavior. ★

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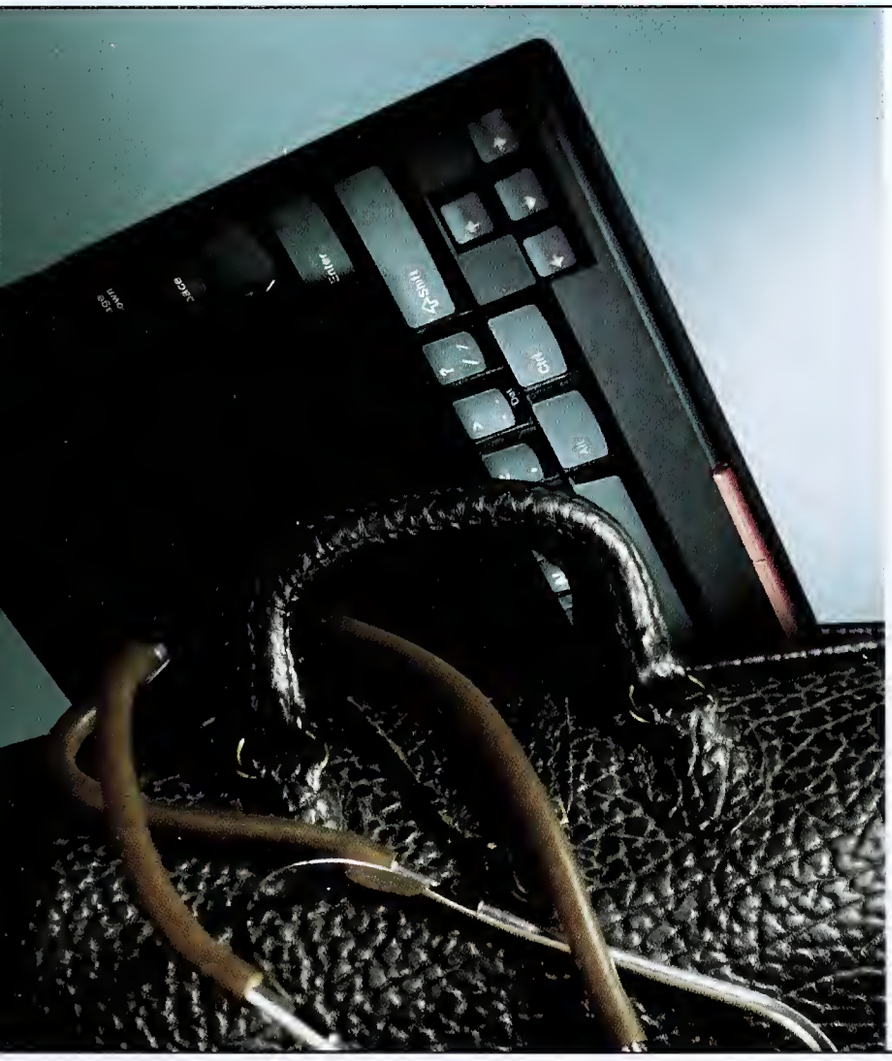

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Texas Medicine
Volume 95 Number 10
October 1999

Symposium on Environmental Medicine

Jeffrey L. Levin, MD, MSPH
Guest Editor

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The *Texas Medicine* Continuing Medical Education Program

A 1997 *Texas Medicine* readership survey revealed that 40% of respondents find the symposium issues of the magazine helpful. At its February 1998 meeting, the Editorial Committee for *Texas Medicine* discussed the growing interest in environmental medicine, the impact of the environment on patients in Texas, and the lack of published information about environmental medicine. At that time, the Editorial Committee scheduled the Symposium on Environmental Medicine for the October 1999 issue of the magazine.

For the first time, *Texas Medicine* is offering member physicians the opportunity to earn continuing medical education credit.

Accreditation

The Texas Medical Association is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians. The Texas Medical Association takes responsibility for the content, quality, and scientific integrity of this continuing medical education activity.

Hour designation

The Texas Medical Association designates this continuing medical education activity for a maximum of 2 hours in Category 1 credit toward the American Medical Association Physician's Recognition Award. Each physician should claim only those hours of credit that he or she actually spends in the educational activity. This credit is available for the period of October 1, 1999, to October 1, 2000.

Continuing medical education credit

Physicians who read the articles in the Symposium on Environmental Medicine (pp 36-76), complete the Self-Assessment/CME Evaluation Form (p 77), and mail in the form are eligible for continuing medical education credit.

Educational methods

To participate in this continuing medical education activity, physicians must read the symposium articles and complete the Self-Assessment/CME Evaluation Form.

Learning objectives

Upon completion of these articles, participants should be able to define environmental and occupational medicine; recognize the importance of a detailed and comprehensive occupational and environmental history as an element of diagnosis; describe the National Association of Physicians for the Environment; discuss the role that research has played in environmental health and science; explain the effect of environmental pollutants on the respiratory system; describe environmental regulations and recognize the range of activities that are subject to regulation; define the role of physician involvement and cooperative efforts among governments and communities in improving air quality; describe occupational asthma; summarize the report of a November 1997 incident in which two teenagers removed a large amount of metallic mercury from an abandoned sign plant and distributed the materials among friends; and identify the role of physicians in communicating environmental risks to patients.

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Author disclosure of commercial affiliations

Policies and standards of the Food and Drug Administration, the American Medical Association, and the Accreditation Council for Continuing Medical Education require that authors of continuing medical education articles disclose any significant financial interest, relationships, or affiliations they may have with commercial entities whose products, devices, or services may be discussed in their articles. They also must disclose discussion of investigational or unlabeled uses of a product.

In accordance with the above policies, the following author has asked that *Texas Medicine* advise participants in this activity that he has an affiliation with the following companies or will be discussing unlabeled uses of a product:

> Jeffrey L. Levin, MD, MSPH, consultant for the Association of Occupational and Environmental Clinics and for the Agency for Toxic Substances and Disease Registry.

The remaining authors had nothing to disclose.

Symposium on Environmental Medicine: Into the next millennium

Jeffrey L. Levin, MD, MSPH
Guest Editor

CME learning objectives

Upon completion of this article, participants should be able to define environmental medicine; to identify the role of physicians in communicating environmental risks to patients; and to recognize the importance of integrating environmental medicine into medical education.

Physicians and other health care providers are witnessing a growth in the number of patients who present with concerns related to environmental exposures. Environmental medicine emphasizes evaluation and prevention of exposure-related illness. Both patients and their communities view physicians as credible sources of information about environmental health matters; however, the knowledge and training that physicians have in this area are generally limited. Recognizing this shortcoming, the Institute of Medicine (IOM) has recommended that competency-based training be integrated into all levels of medical education for physicians. This symposium issue includes articles written by Texas physicians from various forms of practice, and complements the IOM learning approach by serving as a resource of information. The goal is to increase knowledge and awareness of environmental issues among physicians who play a special stewardship role for our planet and the health of its human inhabitants.

Increasingly, physicians and other health care providers in clinical practice are confronted by patients with signs, symptoms, and concerns that they attribute to environmental causes (1). Such causes may include 1 or any combination of chemical, physical, or biologic exposures that have occurred at work, at home, or elsewhere. Questions relating to radon in homes, lead exposure in the workplace, and asbestos in public buildings are but a few examples.

The level of the public's sophistication is such that patients concerned about environmental health hazards often want answers to specific questions about risk. Examples of such questions are the following: What is the likelihood of having a child with birth defects due to exposure from a computer's electromagnetic fields during pregnancy? What are the chances of a family member developing leukemia from nearby power lines? Could the recent cases of cancer in a neighborhood be related to the waste disposal facility close by (2)?

Patients rely upon their physicians to provide this information because they trust and respect them, and they value their opinions and advice. Physicians remain a credible source of information on health matters, including those of an environmental nature, for their patients and the community. Despite this fact, doctors often lack adequate training and information on such issues. Estimates are that only 40% of our medical schools integrate any material about occupational and environmental medicine into their curricula, with an average of 4 hours during the typical 4-year training period (3).

Environmental medicine

What is environmental medicine and how does it relate to environmental health? In broad terms, the environment is a major determinant of health and can be responsible for significant morbidity, mortality, and economic costs (2). Environmental medicine focuses on the relationship between the individual, with his or her intrinsic characteristics, and agents and stresses in the environment (1).

Historically, environmental health was interested largely in the study and control of infectious diseases (1). In

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the last 3 to 4 decades, attention has shifted to the chemical and physical hazards in the environment. In fact, this paradigm shift accompanied a number of evolutionary changes in our modern society. Key among these have been the following changes:

- Increased recognition of the occupational setting as an important contributor to environmental illness;
- Growth of chemical use in our society;
- Generation of increasing quantities of chemical waste and by-products;
- Escalation in the number of environmental disasters;
- Rise of regulatory controls through a variety of laws and federal and state agencies; and
- Most recently, the globalization of our economy with a decline in the definition of geographic boundaries ("pollution knows no borders") and the rise of social environmental stresses.

The tools of occupational medicine, epidemiology, toxicology, and public health are now being applied to environmental medicine (1). An understanding of the distinction between environmental and occupational exposures has become more apparent. Environmental exposures are more often multiple, involve more than 1 route of entry, are typically of more chronic duration, and span all age groups. Their low level tends to make dose characterization and interpretation of nonspecific signs and symptoms difficult (4). As late as 1991, given the increased awareness of nonoccupational environmental exposures and their impact on clinical patient management and public health, the American College of Occupational Medicine changed its name to the American College of Occupational and Environmental Medicine (5). In 1995, the name of the college's journal was changed to *Journal of Occupational and Environmental Medicine* to incorporate the environmental component (6).

The emphasis on evaluation, quantification, and modification or prevention of exposure offers environmental medicine its unique opportunity to link clinical practice and public health (1). Exposure assessment, diagnosis, and prevention are the key features of clinical environmental practice, while treatment (other than control and reduction of exposure) falls within the domain of other specialties.

That environmental medicine concentrates on human health rather than other important issues such as environmental quality and biodiversity is easy to see (1). However, the tide is changing slowly as physicians come to recognize the important consequences that the lack of attention to environmental quality can have for human health. Unfortunately, medical training, knowledge, understanding, and active involvement in these matters have lagged significantly behind other disciplines, particularly as they relate to our ability to appropriately communicate risks to our patients.

The role of communicating environmental risk to individuals is by no means exclusive to physicians; health care providers certainly have a unique opportunity to participate (1). But participation is not an easy task, often complicated by unbalanced patient fears and perceptions. The use of risk comparison can be an effective tool to help patients determine their own risks, as discussed later in this symposium issue.

Environmental education in primary care

Understanding the relationship between health and the environment requires that knowledgeable physicians participate actively as clinicians as well as in a public health context (2). In 1988, the Institute of Medicine (IOM) examined the role played by primary caregivers "on the front lines" in occupational and environmental medicine (7). Recognizing the lack of formal training in the medical curriculum, the IOM suggested that, as a minimum, all primary care physicians should be able to identify conditions that may be induced occupationally or environmentally and to make appropriate specialty referrals. Such a goal would necessitate enhanced physician education and training.

Accomplishing this task in an already overcrowded curriculum and in the face of a rapidly changing health care system would not be easy, in spite of the important reasons for doing so (7). The IOM believed that because environmental medicine permeates the spectrum of medical practice, this discipline should also be "integrated, enhanced, and continually reinforced" throughout the continuum of medical training — in the medical school curriculum, postgraduate residency years, and continuing medical education.

In 1993, the IOM's Committee on Curriculum Development in Environmental Medicine stated that specifying teaching content is not as effective as describing knowledge content and skills that should be possessed at the end of training (2). This competency-based philosophy led to development of the following 6 learning objectives, later incorporated into the committee's report on integrating environmental medicine into medical education:

- Graduating medical students should understand the influence of the environment and environmental agents on human health based on knowledge of relevant epidemiologic, toxicologic, and exposure factors.
- Graduating medical students should be able to recognize the signs, symptoms, diseases, and sources of exposure relating to common environmental agents and conditions.
- Graduating medical students should be able to elicit an appropriately detailed environmental exposure history, including a work history, from all patients.
- Graduating medical students should be able to identify and access the informational, clinical, and other resources available to help address patient and community environmental health problems and concerns.

- Graduating medical students should be able to discuss environmental risks with their patients and provide understandable information about risk-reduction strategies in ways that exhibit sensitivity to patients' health beliefs and concerns.
- Graduating medical students should be able to understand the ethical and legal responsibilities of seeing patients with environmental and occupational health problems or concerns (2).

Symposium on Environmental Medicine

Using this background as a springboard brings us to this symposium issue of *Texas Medicine.* Texas has one of the largest component societies of the American College of Occupational and Environmental Medicine, one of the nation's largest concentrations of petrochemical industries along its Gulf Coast, and the longest common border with Mexico among the 4 border states. Throughout Texas, the population and industry are as diverse as the ecosystems and terrain. The state also has one of the country's highest litigation rates relating to occupational and environmental matters. These factors among numerous others require an increased understanding of what environmental medicine is and what current issues and resources exist that can complement the IOM learning approach through integration into continuing education.

The following articles, all originating in Texas, illustrate and point to the breadth of available resources in our state. These sources of information include academia, private practice, and private industry. In this symposium issue, the authors cover topics ranging from what environmental medicine is and the unique language it uses to the roles for physicians and research scientists in making a better place to live. Special coverage of current topics such as border environmental health issues, the rise in occupational asthma, risk communication, and an actual case of environmental exposure in a Texas community have been included as illustrations of the scope of the problems encountered.

I hope this symposium issue will, in part, accomplish the objectives of the IOM by helping to "integrate, enhance, and reinforce" the knowledge of physicians in our state in this critical area of medicine. More importantly, I hope it will enhance the competence of today's and tomorrow's physicians in managing the growing environmental health concerns of their patients and communities as we enter the next millennium, and in fostering a stewardship role among physicians for our planet and its inhabitants.

Acknowledgment

I would like to offer my sincere thanks to all the authors for their valued contributions to this symposium issue of *Texas Medicine.*

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Environmental awareness among physicians: what are environmental health and environmental medicine?

Fredrick W. Kersh, DO, MS

Arthur L. Frank, MD, PhD

CME learning objectives

Upon completion of this article, participants should be able to describe occupational and environmental medicine, epidemiology, toxicology, and industrial hygiene; to define the terms "environment" (with its three basic components — home, workplace, and the community at large) and "environmental hazard"; to recognize the importance of a detailed and comprehensive occupational and environmental history as an element of diagnosis; and to locate additional information through government agencies, organizations concerned with environmental and occupational health, and databases.

Increased awareness of environmental health issues by the biomedical community and the general public places higher demands on all health and medical practitioners to understand the key terms and concepts related to environmental health and medicine. We all exist in 3 different environments (home, workplace, and community), each of which has its own array of hazards and means of exposure. Environmental medicine is a discipline that addresses preventive measures and provides assessment, diagnosis, and treatment of persons who experience adverse health effects of environmental exposures. In addition to basic clinical skills, environmental medicine uses specialized tools including biostatistics and epidemiologic studies, the science of toxicology and risk assessment, the discipline of industrial hygiene, and administrative and public policy skills. Examples of environmental issues that are faced by society today include asbestos exposure in public buildings as well as pesticide and other agricultural chemical residues present in various environmental media.

Introduction

The medical and scientific community as well as the general public expresses increasing awareness of and interest in the effects of occupational and environmental exposures on health. To be convinced of the truth of this statement, we need only to scan the tables of contents in various scientific and nontechnical books and periodicals. A good example is *Earth in the Balance*, written by Vice-President Al Gore (1992). His words reflect considerable public sentiment:

> And if we do not see that the human part of nature has an increasingly powerful influence over the whole of nature — that we are, in effect, a natural force just like the winds and the tides — then we will not be able to see how dangerously we are threatening to push the earth out of balance (2).

Another good example is *Living Downstream — An Ecologist Looks at Cancer and the Environment* by Sandra Steingraber, PhD. She has the unique perspective of being a trained biologist with the scientific background to understand many of the technical aspects of carcinogenicity, toxicology, and risk assessment, as well as being a cancer survivor who can approach the topic in a very personal way. She writes as follows:

> Ten thousand years of tallgrass prairie have left a fainter trace on the place I call home than 27 years of DDT spraying. Because it is my home, I am driven to pursue the question of the past and ongoing contamination of Illinois and its possible link to the increasing frequency of cancer there. I believe that all of us, wherever our roots, need to examine this relationship. And I think it reasonable to ask — more than three decades after *Silent Spring* alerted us to a possible problem — why so much silence still surrounds questions about cancer's connection to the environment and why so much scientific inquiry into this issue is still considered "preliminary." From dry cleaning fluids to DDT,

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harmful substances have trespassed into the landscape and have also woven themselves, in trace amounts, into the fibers of our bodies. It is not only reasonable but essential that we should understand the lifetime effects of these incremental accumulations (2).

These concerns also are becoming increasingly global as it has become obvious that "the impact of pollution and environmental degradation is no longer a local issue susceptible solely to local or national remedies" (3). The World Health Organization has recently invested considerable resources to study these issues and has published several documents reflecting the concerns of the international community (4,5).

Case study #1

A middle-aged art gallery owner in New York City lived usually in a small apartment near the gallery but had also a large house in Connecticut. After playing tennis in early spring, she developed lower back pain; to save walking steps in the Connecticut house, she moved into a daughter's bedroom on the first floor. Approximately 10 days later, while continuing to have back pain, she also experienced a severe case of dizziness. She returned to New York, was examined by her doctor, and was told to continue to rest and to take a nonsteroidal anti-inflammatory drug (NSAID).

That weekend she went to the Connecticut house for bed rest and continued to take the medication. She then developed diarrhea that was blamed on the NSAID; its use was discontinued. She remained at the country house. Approximately 1 week later, she experienced a severe case of diarrhea and stomach cramps, with generalized weakness. This syndrome continued over the weekend, and the intestinal symptoms worsened. Her weakness progressed, and she developed transient pain in her hands and legs. She began to lose weight and became very thirsty. Walking and standing became difficult.

She consulted her internist again, approximately 1 month after the onset of symptoms. A chest radiograph at that time revealed no abnormality, although she had developed a dry cough with wheezing. She continued to lose weight, and a gastroenterologist found only rapid motility in her gastrointestinal tract.

The patient continued to experience a pulling sensation in her legs, associated with twitching and severe pain along the nerve distribution in her abdomen. She began to experience memory loss, diplopia, and other visual disturbances. She also experienced speech difficulties. On 2 occasions, 1 month apart, she was seen again by her physician, who found nothing abnormal in her laboratory test results.

She was referred to a psychiatrist, who determined that this syndrome was not totally caused by depressive symptoms but believed that the cause was physical. She then underwent a series of medical evaluations by a gynecologist, an endocrinologist, and an infectious disease specialist. These evaluations ruled out diabetes and multiple sclerosis. Parasitic infection was considered but could not be proved.

The patient spent a restful month-long summer vacation on the West Coast, and her symptoms disappeared. Upon returning to the East Coast, the patient lived in her New York City apartment and continued to feel well.

At this time, a colleague showed the patient a magazine article about pesticide poisoning. When she called her exterminator, she learned that an organophosphate to combat fleas had been sprayed twice at the Connecticut home before the onset of symptoms, once in great quantity in her bedroom; the carpet, drapes, bed, and other furniture had been sprayed. Later, when symptoms worsened again, they were associated with monthly spraying not only in the house but also with additional organophosphates on the lawn. Armed with this information, her physician properly diagnosed her illness as a reaction to organophosphates, and slowly her symptoms resolved (6).

Case study #2

A scientist at a government laboratory, knowledgeable about potential health effects of toxic materials, enjoyed competitive pistol shooting as a hobby. He was noted to use hearing protection at the range, but further discussion revealed that he made his own bullets in an unventilated basement, using a heated cauldron to melt the lead. Although he had no clinical symptoms, measurement of his blood lead level revealed a markedly elevated value of 50 μg/dL. The level of lead in his blood returned to normal after he stopped manufacturing his own bullets.

What is occupational and environmental medicine?

Occupational and environmental medicine constitutes a major subsection of the broader field of environmental health. This field of medicine should be included in the practice of all physicians, but there are specialists with training and credentials in these areas. Occupational physicians receive their diplomate credentials from the American Board of Preventive Medicine, and most belong to a specialty society known as the American College of Occupational and Environmental Medicine. In 1990, the American College of Occupational and Environmental Medicine appointed an ad hoc committee to develop a consensus definition of environmental medicine. The following definition resulted.

Environmental medicine is the discipline of medicine that

- Addresses the prevention of adverse health effects caused by physical, chemical, biological, mechanical, and psychosocial factors of individual and group interactions with the environment;
- Provides assessment, diagnosis, and treatment of those individuals who experience observable adverse health effects from their interaction with such factors in the environment;
- Utilizes skills and experience in biostatistics, exposure assessment, epi-

demiology, toxicology, radiation biology, and ergonomics to help achieve these objectives; and
- Serves as interface between clinical and population-based medicine by virtue of knowledge and expertise in public health and clinical medicine (7).

Clinical environmental medicine should not be confused with clinical ecology. Clinical ecologists are a group of approximately 400 physicians in the United States and Canada who belong to the American Academy of Environmental Medicine. Clinical ecology is not a recognized medical specialty whereas occupational and environmental medicine is a specialty component of the American Board of Preventive Medicine. Clinical ecologists often diagnose and treat patients who have multiple chemical sensitivity (MCS). One of the leading practitioners of clinical ecology is William J. Rea, MD, who has treated many patients at his Environmental Health Center in Dallas. He has defined MCS as "an adverse reaction to ambient doses of toxic chemicals in our air, food, and water at levels which are generally accepted as sub-toxic. Manifestation of adverse reactions depend on the tissue or organ involved, the chemical and pharmacological nature of the toxin, the individual susceptibility of the exposed person, the length of time of exposure, the amount and variety of other body stressors and synergism at the time of reaction, and the derangement of metabolism that may occur from the initial insults" (8).

The clinical ecologists and their followers have proposed a theory of pathogenesis that attributes the illness to immune dysfunction caused by an excessive cumulative burden of xenobiotic materials in susceptible individuals (9). The theories and practices of this field have not been endorsed by the American Medical Association, the American College of Physicians, the Canadian Psychiatric Association, the International Society of Regulatory Toxicology and Pharmacology, or the American Academy of Allergy, Asthma, and Immunology. Critics of clinical ecology have suggested that MCS has never been defined clearly, that no scientifically plausible mechanism has been proposed for it, that no diagnostic tests have been substantiated, and that not a single case has been validated scientifically (10).

Definition of terms and concepts

For a relevant and useful discussion of environmental health and medicine, several terms and concepts need to be defined. The term "environment" in relation to humans can be divided into 3 basic components: home, workplace, and the community at large or global environment. Each has its own set of potential types and sources of harmful exposures, although many agents are common to multiple environments. "Environmental hazard" refers to diverse phenomena that have the potential to adversely affect human health and that can be classified further into chemical agents (eg, heavy metals, pesticides, and solvents), physical agents (eg, ionizing and nonionizing radiation, noise, and temperature), biologic agents (eg, bacteria, viruses, fungi, and allergens), psychosocial factors (eg, personal, family, and coworker), and traumatic factors (eg, acute and cumulative). These hazardous agents can enter the environment in 1 or more of 5 ways: first, direct discharge such as pesticide application or smoke stack emissions; second, direct exposure such as in environmental tobacco smoke or lead in paint; third, dumping material onto soil or into waterways in an illegal manner; fourth, inadequate landfills that fail to prevent runoff, leaching, or travel through the food chain of hazardous agents; and fifth, catastrophic events such as the incidents at Chernobyl or Bhopal.

The media of environmental hazard transmission include air, water, soil, food, and biologic vectors such as insects. Two additional media that are becoming increasingly important are parenteral transmission for the health care worker and/or intravenous drug abuser, and fire in the form of incineration of hazardous waste. In the assessment of human exposure to toxic environmental hazards, 4 characteristics are important: route of exposure — inhalation, ingestion, dermal, parenteral, and transplacental; magnitude of exposure — concentration or dose; duration of exposure; and frequency of exposure.

Other issues that influence the outcome of hazardous exposures include host susceptibility factors such as age, race, gender, underlying diseases, genetics, nutritional status, and emotional state. Another factor relevant to exposure to certain agents, such as carcinogens, is that of latency, in which the disease (cancer) may not manifest for many years or even decades. Finally, some factors are difficult or impossible to measure in any given case but are known to play important roles in the outcome; eg, the interaction between multiple chemical agents in the environment or in the body, and the influence of physical factors such as sunlight, humidity, or microbial biotransformation on hazardous agents (11).

Back to basics

First and foremost, the tools of the practice of environmental medicine include the same clinical skills and acumen that form the foundations of the practice of any other field of medicine. Physicians are trained, beginning in medical school, to recognize the important elements of diagnosis, so that therapy can be started and prognosis assessed accurately. Of the 3 elements of patient assessment — history, physical examination, and laboratory analysis — the history is critical. Some authors suggest that the medical history makes up the bulk of the information to be collected by the physician, and that if it has been conducted properly, the physical examination and laboratory tests usually only confirm what has been learned from the history. Nothing is different in the approach to making diagnoses related to environmental exposures. The basic approach, which was laid down by Hippocrates centuries ago, has varied little over

time. The only significant addition to this approach was a question added by Bernadino Ramazzini, a physician who in 1700 wrote that it was important for physicians to ask their patients what they did for a living; in our society, we need to expand the questioning to include environmental exposures. In the last edition of *De Morbis Artificium* (1713), Ramazzini laid out the approach to making environmental and occupational assessments and cataloged for the first time many specific occupational and environmental diseases. The importance of a detailed and comprehensive occupational and environmental history cannot be overemphasized in the diagnosis of these disorders (6).

In addition to these basic clinical skills, the practice of environmental medicine requires the use of other tools that are especially well suited to this field. These tools include biostatistics and epidemiologic studies, toxicology and risk assessment/risk communication, industrial hygiene and exposure assessment, and administrative and public policy issues.

Epidemiology is defined generally as the study of the distribution of diseases in the human population and of any determinants of that distribution. Specific characteristics of people, including their commonalities and differences, can be examined for possible causal relationships with the occurrence of diseases. Because epidemiologic studies draw conclusions from observations of the natural distribution of diseases in human populations (humans are the study subjects), they avoid the problem of extrapolating from animal experimentation. The exposure conditions and the appropriateness of the specific animals used in these experiments have been questioned frequently. However, epidemiologic studies usually provide less conclusive results than do experimental studies because of the nature of the observational methods used in these studies as contrasted to the controlled laboratory methods used in the experimental investigations.

Toxicology is the study of the adverse effects of chemical, physical, or biological agents on living organisms. Toxicologists examine the nature of these effects, including the cellular, biochemical, and molecular mechanisms of action, and predict the probability of their occurrence. Risk assessment is the use of these toxicologic principles to estimate quantitatively the effects of these exposures on human health and the environment. Adverse effects of a toxic agent are not produced unless the agent or its biotransformational products reach appropriate sites in the body at a concentration and for a period of time sufficient to produce a toxic manifestation. Thus, the field of toxicology is involved in assessing the route and site of exposure, the duration and frequency of exposure, and the spectrum of undesired effects in various living systems. The dose-response relationship is a fundamental concept in toxicology where the characteristics of exposure are correlated with the spectrum of effects (12).

Industrial hygiene is a scientific and technical field that has as its main goals the recognition, evaluation, and control of health hazards in the workplace. The same goals and the same or at least similar methodologies apply to environmental health hazards. The industrial hygienist is usually a graduate level professional who determines the need for medical surveillance or special examinations of persons exposed to particular agents:

- Evaluating whether exposure to an occupational or environmental hazard may have contributed to the development of an occupational or environmental illness;
- Determining the presence of potential offending agents through sampling strategies and comparing them with established and recommended standard levels of "safe" exposures;
- Assessing the adequacy of ventilation systems in outbreaks of illness, such as indoor air pollution; and
- Complementing the efforts of a physician who has completed a preliminary plant or site walk-through.

Today's examples

Several representative environmental issues provide useful examples. These include asbestos exposure in public buildings, and pesticide and herbicide residues present in various environmental media.

Asbestos ranks among the most widely discussed environmental toxicants. Respiratory and associated wasting diseases secondary to asbestos exposure were noted in Europe and Great Britain by 1898. The adverse health effects are well substantiated in modern medical literature and include asbestosis, lung cancer, and pleural diseases including malignant mesothelioma. Occupational exposures to asbestos from mining and milling as well as from manufacturing processes and installation of asbestos-containing products have been so well addressed — not only by the medical community but at the legislative and policy level — that significant decreases in these exposures have been accomplished.

However, a major remaining concern is with low-level, long-term exposure that occurs in public and private buildings in which asbestos building materials are still in place. These exposures are predominantly airborne fibers from deteriorating building materials or inappropriate methods used for removal but also include waterborne exposure from asbestos-cement water pipes. In 1986, Congress passed the Asbestos Hazard Emergency Response Act (AHERA), which addressed inspection and abatement of asbestos in public schools. This act has remained a controversial measure, with critics citing that this asbestos exposure does not pose a significant risk to human health and that the considerable money spent on it would be spent better elsewhere. Nonetheless, that asbestos exposure from any source places humans at potentially increased risk of adverse health is without question.

Approximately 1 billion pounds of pesticides, herbicides, and other agricultural chemicals, including fertilizer, are applied to agricultural crops in the United States annually. These chemicals

Table 1. Sources of technical information.

Material safety data sheets (available from agencies and companies)
Poison control centers
State and local health departments
Academic institutions (National Institute for Occupational Safety and Health-sponsored environmental resource centers and program projects)
Medical libraries

Table 2. Technical databases.

CCRIS	Chemical Carcinogenesis Research Information System
CHEMLINE	Chemical Dictionary On-LINE
DBIR	Directory of Biotechnology Information Resources
ETIC	Environmental Teratology Information Center
HSDB	Hazardous Substances Data Bank
MEDLARS	Medical Literature Analysis and Retrieval System, National Library of Medicine, (888) 346-3656
RTECS	Registry of Toxic Effects of Chemical Substances
TOXLINE	Toxicology Information Line
TOXLIT	Toxicology Literature
TOXNET	Toxicology Data Network, National Library of Medicine, (301) 496-6531
TRI	Toxic Chemical Releases Inventory, National Library of Medicine, (800) 496-6531

Table 3. Organizations concerned with environmental and occupational health.

American College of Occupational and Environmental Medicine
American College of Preventive Medicine
American Lung Association
Association of Occupational and Environmental Clinics
American Public Health Association
Agency for Toxic Substances and Disease Registry
Collegium Ramazzini
Consumer Product Safety Commission
Department of Energy
Department of Transportation
Environmental Protection Agency
International Labour Office
National Cancer Institute
National Institute for Environmental Health Sciences
National Institute for Occupational Safety and Health
Nuclear Regulatory Commission
Occupational Safety and Health Administration
Society for Occupational and Environmental Health

are sprayed primarily and potentially expose workers and the general public in many ways. Groundwater, well water, and soil are contaminated by farm chemicals through water runoff, drainage, seepage, and spraying. Contamination of these environmental media by nitrates, pesticides, halogenated hydrocarbons, and other toxic materials is now recognized as a health risk to humans as well as to domestic animals, livestock, and wildlife. For example, nitrate contamination of well water and groundwater has been a source of methemoglobinemia in inhabitants of rural areas. In addition, many of these nitrogen-containing compounds can react chemically with acidic soil and water to form the potentially carcinogenic nitrosamines. In the past, such chemicals have been regarded as less significant causes of pollution than landfills, industrial disposal, and other "point sources." However, with the use of long-duration, real-time methods for assessing exposure and with computerized mathematical modeling techniques, these "non-point-source" agricultural contributions are now being implicated as significant to the overall picture of pollution (13).

Agencies and information resources

A number of government agencies and environmental laws play an important role in environmental health and medicine. The agency with the greatest impact on this field is the Environmental Protection Agency (EPA), which was created to identify harmful substances and to regulate the handling, emission, discharge, or disposal of those substances. EPA establishes national standards under federal statutes such as the Clean Air Act, the Clean Water Act, the Resource Conservation and Recovery Act, the Safe Drinking Water Act, the Toxic Substances Control Act, the Federal Insecticide, Fungicide, and Rodenticide Act, and the Comprehensive Environmental Response, Compensation, and Liability Act, which was expanded by the Superfund Amendments and Reauthorization Act of 1986. EPA enforces these statutes with permits, which define specifically the requirements of the statute for an industry or a regulated substance. Federal law allows states to set standards that must be at least as strict as federal standards, and EPA approves and oversees these state programs.

Other government agencies that play an important role in occupational and environmental health and medicine are the Occupational Safety and Health Administration, the National Institute of Occupational Safety and Health, the Food and Drug Administration, the Consumer Product Safety Commission, the Department of Energy, and the Department of Agriculture.

Increasing awareness of environmental issues is accompanied by increasing expectations on the part of all parties involved. Patients who believe that they may be facing the adverse consequences of toxic exposures expect their physicians to recognize and appreciate these consequences and to of-

fer intervention where appropriate. Corporate entities recognize the massive and potentially devastating liabilities that can accompany adverse environmental outcomes and catastrophes, eg, the Exxon Valdez incident. The costs of these occurrences are great, but the effects on corporate reputation and the costs of lost opportunity may be even more damaging.

Many sources of additional information on these issues are available. Some are included in Tables 1 through 3. A recommended reading list of relevant textbooks and journals is included, also. Texas has a number of academic departments concerned with occupational and environmental health among the state's universities and medical schools. Four offer residency training programs: The University of Texas Health Center at Tyler, The University of Texas-Houston School of Public Health, The University of Texas Medical Branch at Galveston, and the US Air Force training program at San Antonio.

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Commentary

Physicians' role in environmental issues

Byron J. Bailey, MD

CME learning objectives

Upon completion of this article, participants should be able to describe the National Association of Physicians for the Environment — its history, services, and current priorities; to recognize the key role of physicians in educating patients about the impact of pollution on their health; and to contact the National Association of Physicians for the Environment to join in its efforts to prevent pollution, preserve biodiversity, enhance the quality of the environment, and improve the health of patients.

Our health and the health of our patients are linked closely to the quality of our environment. As physicians, we ourselves must learn and then we must educate our patients about the importance of preventing health-endangering pollution of our air, water, food, and soil. As busy physicians, we need access to the most current, important new scientific information regarding environmental degradation where our patients work and live so we can appreciate the clinical problems that some patients present to us today.

The National Association of Physicians for the Environment (NAPE) is an organization of physicians and 46 medical professional societies serving to promote protection of the environment as a fundamental responsibility of physicians and other health professionals. NAPE sponsors national conferences, promotes the publication of current "best practices" information in various general and specialty areas, and serves as a national forum for the discussion of issues and dissemination of scientifically valid information needed for physician and patient education.

Background

The evidence continues to grow in support of the concept that human health is linked closely to the environment in which we live. Physicians have recognized that when our environment deteriorates, inevitable harmful effects on the health of our patients follow. So the question arises for each of us, "What can I do, as one person, to make a difference?"

Because the issues are complex, we need a source for the best scientific information we can find that will help us to educate ourselves on environmental matters. Because the scope of the problem is so broad, we need to link up with other physicians (and physician organizations) to have an impact.

This is the background that led to the formation of the National Association of Physicians for the Environment (NAPE), a group of physicians who believe that "Pollution Prevention is Disease Prevention." As the current president of NAPE, I want to inform you about our organization and invite you to join us in this important effort.

NAPE's mission is to promote responsibility for protection of the environment as an integral part of the healing mission of physicians and other health professionals, and to inform the public that every environmental or pollution problem is, or will become, a medical or public health problem. Pollution prevention is disease prevention.

Physician education on environmental issues

NAPE became active in the environmental movement in February 1993, when it first convened for the Conference on Physicians and the Environment in Washington, DC; funding came from the National Institute of Environmental Health Sciences (NIEHS) of the National Institutes of Health (NIH). NAPE has moved forward to establish an educational network involving 46 professional organizations and more than 200 individual members. Working through the resources of existing national medical specialty societies, NAPE has increased the effectiveness of physicians as they deal with commu-

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nity and individual health effects of environmental pollutants on the organ systems and disease processes with which each specialty is most familiar.

During the past 5 years, NAPE has begun to inform physicians, patients, and the public generally about the impact of pollution and the actions that must be taken to reduce or eliminate unhealthy pollutants. NAPE has been established as a national forum for the interdisciplinary exchange of environmental health information; the organization fills the void that exists in the absence of any other consortium of medical societies working together to deal with the growing environmental concerns of physicians. NAPE has convened conferences, disseminated scientifically based environmental information through appropriate educational channels, and fostered debate and the building of consensus on important environmental health issues.

In November 1994, NAPE sponsored the 2-day Conference on the Impact of Air Pollution on Body Organs and Systems at the National Press Club in Washington, DC. While the focus on asthma and lung cancer associated with air pollution and smoking has been brought into the public consciousness through the outstanding efforts of several surgeons general and organizations like the American Lung Association, the time had come to expand the public awareness of the impact of air pollution on all of the organ systems of the body. Alfred Munzer, MD, immediate past-president of the American Lung Association, emphasized this point:

> After all, it's not just the lungs and the lower respiratory tract but also the eyes, the ears, the nose, and the skin that are exposed to environmental pollution. It's not just the lung that serves as a gateway for hazardous pollutants, but it's also the gastrointestinal tract. It's not just lung cancer, but also bladder cancer that's related to smoking. Lead may be inhaled through the lung, but it has its effect on bone, blood, and the central nervous system. Carbon monoxide gains access to the body by the lung but has its greatest effect on the cardiovascular system.

Since 1993, NAPE has sponsored annual national meetings such as the Conference on Biodiversity and Human Health, which was held at the Smithsonian Institute, and the Conference on Water Pollution and Human Health, which was held in Chicago, Ill. After each of these conferences, NAPE has disseminated the conference information widely through various print and electronic communications. NAPE has informed physicians and the public about the threats to health that might result from weakening of the stratospheric ozone layer and consequent increases in ground level ultraviolet B light (UVB). We have been very active in establishing the widespread publication of the local ultraviolet index (UVI) as a part of the routine reporting of the National Weather Service. Recognizing that environmental concerns must be addressed globally, NAPE has worked closely with the International Society of Doctors for the Environment, the main association of physicians addressing these problems from an international perspective.

Under the able and energetic leadership of John Grupenhoff, PhD, the executive vice president of NAPE, we have established programs directed at the "greening" of physicians' offices and hospitals and have launched an important initiative in energy conservation for medical facilities. Dr Grupenhoff has been instrumental in putting together the "Environment and Health Directory," a comprehensive listing of federal, state, and local governmental agencies as well as nongovernmental organizations and persons who are concerned with the environment and its impact on human health. This directory has begun to facilitate communication among all who are working in this area, and is available on the NAPE home page at www.napenet.org, where you also will find much more information about NAPE.

Need for more and better information about air pollution, water pollution, and biodiversity

We are learning more about the information physicians need to serve effectively as an important interface between complex scientific issues and the needs and questions of patients. When we realize that more than 600,000 physicians practice in the United States and that each of us interacts with thousands of patients each year, the key role of physicians in educating patients about the impact of pollution on their health becomes quite apparent. First, however, physicians must educate themselves and must make a commitment to include this area of responsibility in their already packed professional schedules.

For example, physicians need to understand that air pollution constitutes a major health problem, both in terms of its impact on almost every organ in the body and in terms of its economic cost to society when the morbidity and mortality of patients are totaled. Physicians must recognize that the rising incidence of asthma deaths and emergency room visits correlates directly with the rising ozone levels in our cities. Sulphur dioxide emitted from power generation plants and oil refineries is a potent bronchoconstrictor that has been linked to bronchitis and chronic cough and that has been associated with an increased mortality in patients who have underlying heart and lung disease. Carbon monoxide is not only a serious health risk for smokers but also can lead to chronic tissue hypoxia in our cities, where carbon monoxide levels in the blood can become 10 times higher than normal.

The central nervous system (CNS) is the primary target for many serious air pollutants. For example, lead is a major environmental hazard, and children, in particular, remain at risk for the CNS effects of lead in many cities in Texas. Research over the past 10 years has provided evidence that the levels of lead exposure associated with CNS effects, particularly as manifest in behavioral changes, is far lower than ever

previously realized. Fifteen years ago, blood lead concentrations in children were not considered problematic until they exceeded levels greater than 30 to 40 μg/dL. Since that time, more sophisticated epidemiological studies have shown changes in cognitive function at blood concentrations as low as 10 to 15 μg/dL.

At high levels of exposure, pesticides pose serious risks to the nervous system and other organ systems. Pesticides may produce respiratory center failure and/or respiratory muscle weakness, and they may seriously irritate the airway. Prevention of exposures to pesticides is a key to maintaining personal health, and more education is needed, not only for rural farm workers but also for city dwellers who use these products as well.

Ozone is a pollutant that acts to enhance the effect of inhaled allergens in asthmatics, and more than 50% of the population of the United States live in areas that exceed the current national ambient air quality standards for ozone as monitored by the US Environmental Protection Agency (EPA). NAPE has prepared and made available a convenient package of educational materials with illustrative slides that physicians can use to present this important information to either civic or medical groups.

As a result of the important conference held in Chicago, NAPE can provide valuable educational materials regarding water pollution. While we may take our water supply for granted, many cities have experienced serious problems with diseases produced by *Giardia, Cryptosporidium, Cystospora* and coliform bacteria. During the past decade, a number of epidemic outbreaks have been traced to the local water supply; in almost every case, the community has had problems in getting timely and accurate information to physicians and ultimately to patients regarding the exact nature and the best response to these emergency situations. Some of these problems can be traced to a continuing decline in the nature of the source water for our community reservoirs and drinking water. A gradual upward trend has occurred over the past 40 years in the total coliform bacteria level in source water in the United States, and considerable attention is being directed at locating precisely the source for these pathogens. In many instances, the sources can be traced accurately to cows, pigs, poultry, wildlife, or human sources.

The link between biodiversity and human health is extremely important and affects profoundly the way we practice medicine today. "Biodiversity" is the term used to include the entirety of all living organisms on earth. Scientists estimate that this may include more than 10 million species; only 2% or 3% have been characterized even superficially as to whether their makeup might contain molecules that would be useful in preserving health on our planet.

Did you know, for example, that 57% of the 150 drugs that we use most often in treating our patients are derived from the natural world? Are you aware that an extract from the poison found in the skin of a frog in South America may become a valuable new painkiller, 200 times more effective than morphine, that you will use in your practice?

Today, we are losing species at an unprecedented rate. Until now, these species had survived drought, disease, and predators for millions of years — and to do so, most had developed powerful defense mechanisms that might have become future medical products. The world of nature is a library of molecular resources that we should value for the promise they hold to fuel the biomedical advances of the future. Economists predict that biopharmacy will be an annual multibillion-dollar industry in the next century. So it follows that good environmental practices will be good business. Physicians can be leaders in the important task of preserving biodiversity.

Organizing to meet the challenges

Recognizing the enormity of the link between pollution prevention and disease prevention, NAPE has identified key areas where physicians can play an effective role in preserving the quality of our environment and, therefore, the health of our patients. Each year, as we have organized our national conference, we have moved forward with the creation of a national council that has developed an action program and followed up on the important information presented at the conference. We currently have national councils working actively in the areas of air pollution, water pollution, noise pollution, biodiversity, ozone layer/skin cancer, energy efficiency, and special risk populations.

NAPE's highest priorities for 1999

For a small organization, NAPE tackles some pretty big problems. This means that while we must maintain the activities and work already in progress, addressing the challenges that have been identified in previous years, we must also take on new issues that come to the forefront.

During 1999, NAPE continues to encourage physicians to green their offices and hospitals. Working with the Environmental Alliance for Senior Involvement and with the National Wildlife Federation, and supported by a grant from the W. Alton Jones Foundation, we are distributing widely the "Physician's Green Office Guide" that has been developed as a "how-to-do-it" handbook for physicians' office managers who will agree to work to make offices more environmentally sound. The development and distribution of this information is assisted by a grant from the EPA Office of Pollution Prevention and Toxics. The time has come to advance from the several hundred medical offices that have already embarked on the process of greening and increase to several thousand offices and hospitals cooperating in this effort.

During 1999, we have taken on a second major issue that will indeed involve a number of daunting tasks. We believe a major opportunity exists now to *prevent pollution* in research and clinical laboratories, thereby protecting the health of the people and the environment. Both the White House and Congress have indicated their intention

to *increase funding* for scientific research significantly. In fact, some congressional leaders are proposing to double the funding for the NIH in the next 5 years. If this is done, the cumulative total funding for those 5 years could be $119 billion. In fiscal year 2005, the annual NIH research budget would be $26 billion, with a buildup continuing thereafter. The funding for biomedical and clinical research portfolios in other federal agencies will increase as well. This increased grant funding will result in a major economic boom in nonprofit biomedical and clinical research because expenditures for for-profit or commercial/corporate research are expected to be increased greatly as well. Vast amounts will be spent for new construction and upgrades, and for new laboratory and office equipment, with substantial increases in energy consumption. The great increase that will result in the types and volume of waste materials (solid, chemical, medical, pathological, and radioactive) will require management and appropriate disposal.

Two important questions arise: First, how can the environmental health leadership develop a program of pollution prevention and energy efficiency to prevent this enormous growth from creating severe increases in pollution that will endanger the health of our patients? And second, how can such a program spin off by-products than can be used for other areas of scientific research for which increased funding will be available also?

We suggest that a national program must be developed with 3 essential components:

- A national conference to highlight the issues, profile current "best practices," and suggest methods of implementing *environmentally sound practices*;
- Following the conference, development of a *national education and training program* for campuses that receive grants, combining the efforts of the researchers and the facility managers; and
- Development of a *national clearinghouse* to inform the field of "best practices" available for widespread use.

Conclusion

As recently as 5 years ago, no association of medical societies existed to pull together, in an interdisciplinary fashion, the growing environmental concerns of the various medical specialties. No group existed to act as a convener, a transfer agent of information, or a forum for debate and building consensus on the issues, and no coordinated source of public information and education programs could be set in motion nationally and locally. NAPE was formed to fill that need.

The potential influence of NAPE is considerable. Nearly all US physicians (more than 600,000) belong to one or more medical specialty or subspecialty society, as well as national, regional, state, and local general medical organizations. Many of these physicians serve on hospital boards, and almost all are active leaders in some areas of their communities.

Physicians are much more likely to involve themselves in environmental issues if their medical specialties or other medical organizations are involved than they are to become engaged in these issues as individuals. Physicians depend upon and trust their medical specialty societies and their general medical organizations for policy development as well as for continuing professional education and information.

Medical specialty organizations already have in place a national physician education process for their members. Such organizations sponsor peer-reviewed scientific journals and other periodicals that assure the validity of the scientific information upon which physicians base their medical activities and decisions. These organizations and publications are familiar to physicians and are focused on the specific body organs, systems, and diseases with which their members are familiar.

Medical societies have a systematic policymaking apparatus with experienced, intelligent, and able leadership accustomed to working through strong committee systems. They all have groups and committees that are appropriate to develop informational materials with which their organizations are comfortable. In addition, many of the larger organizations have full-time professional staff available to help analyze policy proposals and to make recommendations in an effective way to regional and national policymakers.

NAPE has been developed to work with these national medical specialties and subspecialties as well as with national, state, and local medical societies and with individual physicians as we all come together to deal with the impact of environmental pollutants on the organs, systems, and diseases we know best. NAPE exists to inform physicians, patients, and the public about the impact of pollutants and about the necessary personal and public health steps that we must take to reduce or eliminate those pollutants. NAPE exists to involve physicians in environmental issues, such as the protection of biological diversity, that go beyond pollution prevention.

Each of us has a responsibility to become informed and involved.

Each of us can make a difference individually once we have become informed and involved.

Together, we can have a worldwide impact on public policy that will prevent pollution, preserve biodiversity, enhance the quality of our environment, and improve the health of our patients.

For further information and action

We hope this article has captured your interest. We invite you and your organizations to become members of NAPE, and we hope you will join in this effort and become leaders in addressing these environmental and health issues. Please contact us at NAPE, 6410 Rockledge Dr, Ste 412, Bethesda, MD 20817; fax (301) 530-8910; visit the NAPE Web site at www.napenet.org; or e-mail nape@napenet.org.

The role of research in environmental science and health

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CME learning objectives

Upon completion of this article, participants should be able to discuss the role that research has played in environmental health and science in the past; to identify environmental hazards and their consequences; to explain the effect of environmental pollutants on the respiratory system; and to list the four stages of risk assessment, which estimates the risk to a population exposed to an environmental pollutant at a specific dose.

Research plays a crucial central role between physicians and regulatory agencies in assessing the potential risks posed by an ever-increasing variety of environmental pollutants. The explosion in our understanding of biology and the development of the powerful tools of molecular biology during the last 50 years have provided us with a unique opportunity to apply this knowledge to predict the dangers of these pollutants and to act to protect the public where appropriate. To realize this vision requires multidisciplinary cooperation, continued research funding, and improved scientific literacy among the public. In this article, we do not attempt to review all the literature relating the role that research has played in environmental health and science, but rather we hope to provide the reader with a broad overview of the role that research has played in the past, emphasizing our own area of expertise (the respiratory system) and the role that research should play as our increasingly complex society moves into the 21st century.

Introduction

As we move from an industrial economy to a more technologically based economy, the expectations placed on environmental science have changed. Although less heavy industry usually involves less pollution and lower costs, the evolution of technology often carries new areas of occupational and environmental concern. Technology-based industry is perceived generally as cleaner and less costly, but the public has become more concerned about the overall quality of the environment. While society, at least in the United States, has changed, the role played by research in assessing the dangers posed by environmental hazards remains similar. Environmental research requires interactions among various disciplines and specialties, including clinical medicine, epidemiology, toxicology, and basic science. Academic clinicians, particularly specialists in occupational and environmental medicine, play a pivotal role in this interchange.

In the broadest sense, this process can be defined as a 5-step sequence. The first step is identification of an increased prevalence of a particular pathological state in a defined population by vigilant physicians. The second step involves detailed statistical analyses to determine whether the increased prevalence of a particular disease is significant and whether this can be correlated with one or more potential causes. The third step entails developing hypotheses that link these possible causes to the clinical outcomes, and then testing these hypotheses. This stage may involve environmental testing to identify known as well as unknown causal agents in the environment, and laboratory experimentation to ascertain the biological effects of these agents. These experimental stages entail biochemical, molecular biological, cell biological, and animal experimentation. The recent explosion in molecular biology has yielded highly sensitive assays with which to measure the biological effects of environmental pollutants; we can now assess exposure levels and associated cellular effects using biomarkers and assays for DNA damage, mutagenicity, and changes in signal transduction. While many powerful new

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techniques exist, the limiting factor in their application often remains the common need to obtain funding, usually from federal or state agencies. Paradoxically, while research is facilitated by a multidisciplinary approach, this approach may make the solicitation of funding more problematic because the various funding agencies or study sections tend to be "thematic." The fourth stage in the research process involves governmental review of all of the clinical, epidemiological, and scientific data, followed by a risk assessment and, if appropriate, by the development of measures to protect the public and by legislative action to implement these measures. The final and continual stage entails an ongoing review of the situation to refine or redefine the problem and its solution in the light of further data.

Research plays the crucial central role between insightful observation and ultimate elimination of the problem, either by removing the causal agent or by introducing appropriate protective measures. Unfortunately, most of the funding opportunities in the United States are for individual investigator-initiated studies, despite the global nature of the problems and the diversity of expertise needed to solve them. Efforts to coordinate the work of individual research scientists into specific areas of importance rely primarily on the development of Requests for Applications, which are not as effective as we might wish. A potentially more successful approach is for an institutional philosophy to develop diverse expertise among its faculty, whose collaborative interactions can efficiently and effectively address these complex issues.

Identification of environmental hazards

Each day, we breathe 10,000 to 20,000 L of air along with associated pollutants, particulates, and microorganisms. These constituents may be naturally occurring, man-made, or a mixture of both. Frequently, problems arise simply because ambient concentrations are elevated by human intervention. This is especially true in a closed, indoor environment (the "sick building" syndrome). Problems may arise from industrial sources (eg, power plants, manufacturing plants, and automobile exhaust) and be exacerbated by weather conditions, or they may result from the direct actions of other humans (eg, environmental tobacco smoke). Despite these continual insults, the respiratory defense mechanisms provide extremely effective mechanisms for the clearance of particulates and the neutralization of microorganisms and toxic chemicals. Occasionally, however, the insult overcomes these defenses, and acute illness or death results. Environmental catastrophes such as the Exxon Valdez and those that occurred in Chernobyl and Bhopal are relatively rare, thanks in large part to our understanding of the potential hazards involved and our knowledge of how to react when such situations do occur. Other environmental hazards carry more insidious consequences, and many years may pass before the consequences of exposure become evident. The health hazards associated with asbestos exposure provide a good example.

The useful properties of asbestos have been known for thousands of years, but only in the last 30 years has its darker side become more evident (1). The long latency period for progression of the diseases associated with asbestos exposure (lung fibrosis, lung cancer, and malignant mesothelioma) and the relatively few members of the overall population exposed to asbestos before World War II hindered the identification of the causal link. The ultimate realization of the danger resulted from multiple factors, including the large number of people exposed to asbestos during World War II and the immediate postwar era, longer life expectancy, and better diagnostic techniques. Although few would argue against the carcinogenicity of amphibole asbestos, some still would argue that chrysotile asbestos is harmless, in spite of current research findings that continue to indicate that all asbestos is potentially harmful if inhaled (the position taken by US regulatory agencies).

Unfortunately, a catastrophic exposure and its consequences often provide the insight needed to identify an environmental hazard. Oftentimes, such a disaster may be needed to motivate protection. The lethal consequences of silica dust exposure (silicosis) were known before the Hawks Nest tunnel was constructed; however, the callous disregard of the need for the most basic precautions during the construction of the tunnel and the scale of the human tragedy that resulted (2) led to the strict regulations to control silica dust exposure in the workplace that are in force today.

Often, careful epidemiological studies hint at potential hazards. For example, studies of the inhabitants of central Turkey made in the late 1970s led to the suggestion that a causal link exists between environmental exposure to erionite (a fibrous aluminosilicate zeolite) and a high incidence of the rare malignant mesothelioma and other lung cancers at a relatively early age (3,4). These data have led to experimentation on this mineral to determine the mechanisms by which it induces malignant transformation; the hope is that such studies will improve our understanding of the mechanics of the process and help us determine the risk of other potentially respirable materials. The development and increasing acceptance of meta-analysis to combine the results of multiple studies have added a new dimension to the ability of epidemiological studies to detect potentially hazardous environmental agents (5).

Research

The lung is the principal target for environmental pollutants for various reasons, foremost of which is its selective exposure. Second is the high degree of oxygenation that can exacerbate the toxic effects of pollutants. Finally, the presence of bioactivating systems can generate toxic products from nontoxic precursors (6). Thus, basic research on the cell biology, molecular biology, and biochemistry of the lung and its constituent cells is essential to a full un-

derstanding of the effects of environmental exposure to any substance (7).

Determining environmental health hazards is a multifaceted research operation. For example, the "sick building" syndrome is an area of intense current interest. This phenomenon is believed to be caused by tighter internal climate controls in modern buildings, with a concomitant increase in chemical levels and decrease in indoor air quality. These changes are attributed in part to reduced influx of fresh air as a result of the better use of insulation and an accompanying emphasis on recirculation. To ascertain the effects of unknown organic chemicals on residents in buildings requires, first, detection of the chemical components and measurement of their concentration over a defined time frame. Second, an exposure estimate must be made for each component at various sites within the building. Finally, epidemiological and toxicological research must be carried out to yield a compound-based risk assessment (8).

A major limitation of research into the effects of environmental materials on human health is that any given component is almost always part of a complex and infinitely variable mixture. Furthermore, individual susceptibility to these components may vary greatly. While toxicological studies can determine the effects of acute exposure, determining the effects of chronic exposure is much harder, especially in concert with other agents where effects may be synergistic (9). When the synergism is less clear, assessment is even more difficult. The weak synergistic effects that have been reported for a number of chemicals with elevated noise levels afford an intriguing example (10); to understand the scientific basis of these interactions will entail very complex experimentation.

The National Ambient Air Quality Standards (NAAQS) set appropriate limits for pollutants in ambient air at levels determined to protect the health of normal and susceptible subpopulations. Extrapolation modeling makes possible determination of the effective dose delivered to a susceptible organ. On the basis of the organ's sensitivity, researchers can back-calculate a permissible level in the ambient air.

Animal toxicology studies play an important role. For example, epidemiological studies showed a correlation between homes using gas stoves and increased respiratory illness (11). The initial hypothesis suggesting that high levels of NO_2 suppressed the respiratory defense mechanisms was confirmed by measurements of the concentration in affected areas, followed by animal exposure modeling at these levels. This approach also allows for different modalities of exposure, affecting both concentration and duration of exposure, to be compared. Although animal studies have advantages over purely human epidemiological studies, they also introduce the compounding factor of interspecies variability.

A range of hazardous air pollutants have been identified including gases (eg, NO_2, SO_2, CO, and O_3), volatile organic compounds (eg, formaldehyde, respirable particulates, and radon gas), and asbestos fibers. These derive from numerous sources, including gas stoves and heaters, wood-burning fireplaces, building and insulation materials, and the environment. Cigarette smoking contributes significantly to many of these pollutants. The development of biomarkers to assess actual exposure to or the effects from a toxic agent has added a new dimension to the assessment of exposure (12,13). Detailed reviews of the health effects of outdoor air pollution (14) and indoor air quality (15) are included in the References.

To determine acceptable standards for all air pollutants involves determining the relationship between external concentration and internal concentration as well as the mechanisms of action and the methods and rates of removal. The same is true for particulate exposures. Research has shown that the deleterious effects of asbestos result from a number of its properties. The size of the particles enables them to penetrate deep within the lung. While small fibers can be cleared effectively by the alveolar macrophages, a population of fibers longer than 5 μm cannot be phagocytosed. This results in a chronic inflammatory response and an ongoing respiratory burst as well as the generation of reactive oxygen metabolites via the Haber-Weiss reaction on iron dissolved from the fibers and the iron-protein (ferruginous) material deposited on the fibers by the alveolar macrophages. Since these fibers are so long-lived (they can be recovered in quantifiable amounts from biopsy samples 30 to 40 years after exposure), the continual inflammatory stimulus presumably leads eventually to disease. The role of reactive oxygen species in acute inflammatory reactions and chronic lung disease remains a fruitful area of current research (16).

While animal experiments have great utility in determining the action of particulates once deposited within the lung, the physical structure of the lung as much as that of the particle determines where a given particle is deposited. Because the lungs of animals differ significantly both in size and orientation to those of humans, animals do not provide good models for the actual inhalation process.

Another class of environmental health risk derives from microbiological sources (17). These include hypersensitivity pneumonitis as a consequence of exposure to fungal spores, fecal pellets, and remains of dust mites and to other agents resulting from microbiologically mediated decomposition; and disease resulting from infection with organisms associated with particular environments (eg, Legionella or Hantavirus) or from organisms from an infected individual (eg, *Mycobacterium tuberculosis*) in a closed, indoor environment. Research has played and will continue to play an important role in the identification, control, and treatment of microbiologically induced environmental diseases.

Research can also dispel concern of the risk from a particular potential hazard, especially in situations where the scientific basis for concern is slim. For a while, the possible hazardous effects of

intense electromagnetic fields generated considerable concern. The sources included electricity transmission lines, hair dryers, and, most recently, cellular phones. Public concern was significant, but research has been largely unable to show any direct correlation beyond a slightly increased risk of acute myeloid leukemia in workers in power plants, which could just as likely be the consequence of exposure to some other as yet unidentified agent (18). As a result, what now appears to be potentially unnecessary regulation has been avoided. However, as with other environmental/occupational exposures, further data collected over time may alter the status from "unnecessary regulations" to those necessary to "protect public health."

Risk assessment

Risk assessment estimates the risk to a population exposed to an environmental pollutant at a specific dose. The first step in this 4-stage process (19) entails a *hazard assessment*, based on a review of the scientific literature. The second step is a *dose-response assessment* that evaluates the doses used in the scientific studies and then applies these to human exposures. The third step is the *exposure assessment* in which populations potentially at risk are examined in terms of concentrations of agents in the environment, possible duration of exposure, and potential routes of exposure. The final step is the *risk characterization* in which all of the data are reviewed along with the assumptions and uncertainties, and a predicted incidence of disease will be calculated.

Often, a specific environmental substance can cause both neoplasms and chronic diseases, and the relative risks of these may differ. For example, exposure to occupational levels of amphibole asbestos leads almost invariably to lung fibrosis over time, but the occurrence of lung cancer and of mesothelioma is less common, given the 20-to-30-year time frame of development from first exposure. Models to extrapolate effects seen at high doses to much lower doses or from experimental animals to humans present uniquely difficult problems. Results are uncertain when the routes of exposure used in laboratory experiments differ from those that prevail in the environment, and making allowances for the synergistic effects of other components in the environment or for a person's lifestyle is difficult. In the case of asbestos exposure, the addition of smoking as a variable increases the risk of lung cancer from 5 times to as much as 50 times (20). Even once a formal risk assessment is complete, its meaning can be skewed by "opportunistic individuals and organizations who subvert the methods of science to further social goals" (21). The decline in science literacy of high school graduates only serves to exacerbate this problem. A more detailed discussion of the risk assessment process associated with air pollutants may be found in Möller, Schuetzle, and Autrup (22).

Regulation

Translating research results into meaningful regulations is a complex and frequently political process. As the Industrial Revolution developed, occupational medicine and regulations to protect workers followed with perhaps too long a lag. In the latter half of the 20th century, the emphasis has shifted to extend protection to the public outside the workplace. Current legislation is focused on low-level exposure to toxic agents in complex mixtures, and on which preventive, corrective, or protective measures are the most costly and, consequently, the most politically unpalatable. For these measures to succeed, the public must be educated about the real risks associated with environmental exposures, and an open dialogue must be established between the scientific and medical communities and our elected legislators.

Refinement

The total removal of toxic materials from our environment would obviate the need for protective regulations. Although this might be possible for toxic substances such as chlorinated fluorocarbons, polychlorinated biphenyls, or even for asbestos in buildings, it would be an unparalleled tragedy if their replacements were to produce similar levels of morbidity or mortality. To guarantee that this does not occur, we need to maintain our research enterprise to gain a detailed view of the mechanics underlying the development of disease.

As we gain greater understanding of the disease process and a deeper knowledge of the mechanics underlying genetic predisposition, the regulations controlling environmental pollutants will need to be refined and altered appropriately. For example, the Clean Air Act as amended requires periodic review and revision of all NAAQS to ensure that they are based on the latest scientific information. More effective methods to remove or contain pollutants continue to be developed, usually as the result of national or international legislative initiatives.

We live in a world where technology advances with unprecedented speed. Throughout history, the introduction of new technology has led frequently to new diseases. The use of lead acetate to sweeten wine in the ancient world resulted in lead poisoning; the Industrial Revolution led to black lung in miners and to silicosis in foundry workers; the widespread use of asbestos insulation increased the risk of asbestosis, lung cancer, and mesothelioma; and the advent of the use of ionizing radiation led to an increase in leukemia. Our challenge as we enter the 21st century will be to use research techniques proactively to identify and prevent the risks associated with such new technologies. We should avoid waiting to witness a significant increase in occupationally or environmentally induced disease or disastrous loss of human lives before we react.

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The alphabet soup of environmental regulations

Fredy Polanco, MS

CME learning objectives

Upon completion of this article, participants should be able to describe the following government regulations and recognize the range of activities that are subject to environmental regulations: Clean Air Act; Clean Water Act; Resource Conservation and Recovery Act; Comprehensive Environmental Response, Compensation, and Liability Act; Toxic Substance Control Act; Federal Insecticide, Fungicide, and Rodenticide Act; Emergency Planning and Community Right to Know Act; Occupational Safety and Health Act of 1970; and the Federal Mine Safety and Health Amendment Act of 1977.

As we approach the beginning of the 21st century, our desire to protect and preserve our environment is stronger than ever. Many of the developed and developing countries of the world have enacted legislation to aid the protection of their people and the environment by regulating the manufacture, import, and use of industrial chemicals.

In the United States, government regulations at the national, state, and local levels typically complement the legal system's common law remedies. The most significant development in modern environmental law in the second half of the 20th century has been the growth in environmental statutes that take on the anticipatory, proactive regulatory function that the common law does not.

The following list of environmental statutes is not meant to be exhaustive, and the descriptions of their operative provisions are quite general. These descriptions do, however, show the range of activities subject to environmental regulations in the United States.

The Clean Air Act

The original Clean Air Act (CAA) was passed in 1955, authorizing a research program in the Public Health Service and technical support for local agencies concerned with the abatement of air pollution. Amendments in 1960, 1963, and 1965 added the investigation of motor vehicle pollution and fuel desulfurization as new sources of air pollution (1).

Under the Clean Air Act of 1970, the Environmental Protection Agency (EPA) established National Ambient Air Quality Standards (NAAQS) for 6 common air pollutants (primary pollutants) designated as "criteria pollutants": lead, nitrogen dioxide, sulfur dioxide, carbon monoxide, particulate matter, and ground-level ozone.

The federal government requires each state government to draw up and enforce a "state implementation plan" (SIP), which assigns permitted levels of emissions for all air pollution sources in the state, calculated so as to reduce the overall ambient level of those pollutants in the locality down to the basic federal "primary standard" for each pollutant (2). According to an EPA report in 1996, since 1970 the total emissions for all 6 pollutants are down by 24% even though the US population increased in size by 27%, the domestic economy grew by 90%, and the number of motor vehicle miles driven rose by 111%. Since 1990, the number of metropolitan areas not meeting air quality standards has dropped from 199 cities to fewer than 70 cities (3).

Apart from its NAAQS, the Clean Air Act also requires EPA to regulate toxic air pollutants under the National Emission Standards for Hazardous Air Pollutants (NESHAP). In 1990, Congress directed EPA under the Clean Air Act Amendment of 1990 to set standards requiring maximum controls for 189 toxic compounds. As a result, EPA has issued standards for hazardous air emissions from 18 industries. These standards reduce toxic air emissions by 900,000 tons annually, according to EPA. Section 112 of the 1990 CAA mandates that EPA develop maximum achievable control technology (MACT) standards for major sources of hazardous air pollutants

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(HAP). A major source is a facility that emits, or has the potential to emit, 10 tons per year or more of a single HAP or 25 tons per year or more of a combination of HAPs (4).

The Clean Water Act

The basic federal law authorizing regulations to prevent water pollution can be dated from the Federal Water Pollution Control Act of 1956, as amended in 1961, 1965, 1966, and 1970. The Federal Water Pollution Control Act (FWPCA) Amendment of 1972 replaced the previous language of the Clean Water Act entirely, stating the goal of attaining zero discharge of pollutants by 1985, with an interim 1983 goal of attaining water quality to support fish and wildlife and to be suitable for recreation (1). This statute, which in 1977 was retitled the Clean Water Act (CWA), is also a federal-state partnership, including administration of the National Pollutant Discharge Elimination System (NPDES). EPA under CWA publishes effluent standard regulations for many classes and categories, requiring industry to employ the best available technology (BAT) determined to be achievable for treating each industrial effluent. These regulations apply to every "point source" in the nation. NPDES permits are required for most pipes, ditches, channels, tunnels, conduits, and other discrete conveyances of liquid waste. Presently, EPA oversees more than 57,000 permits, which according to this agency prevent over 1 billion pounds of toxic pollution from entering our nation's waters each year. The Clean Water Act also regulates storm water run-off and spills of potentially hazardous substances (2).

The Resource Conservation and Recovery Act

In 1976, Congress passed the Resource Conservation and Recovery Act (RCRA), which was significantly amended in 1984 through the Hazardous and Solid Waste Amendments (HSWA). RCRA and HSWA divided the universe of waste and hazardous materials into specific categories and established programs to address each.

The "alphabet" of environmental health.

ACM	Asbestos-containing materials
AOEC	Association of Occupational and Environmental Clinics
ATSDR	Agency for Toxic Substances and Disease Registry
BAT	Best available technology
CAA	Clean Air Act
CDCP	Center for Disease Control and Prevention
CERCLA	Comprehensive Environmental Response, Compensation, and Liability Act
CWA	Clean Water Act
EPA	Environmental Protection Agency
FIFRA	Federal Insecticide, Fungicide, and Rodenticide Act
FWPCA	Federal Water Pollution Control Act
HAP	Hazardous air pollutants
HSWA	Hazardous and Solid Waste Amendments
MACT	Maximum achievable control technology
MSDS	Material Safety Data Sheets
MSHA	Mine Safety and Health Act
NAAQS	National Ambient Air Quality Standards
NESHAP	National Emission Standards for Hazardous Air Pollutants
NIOSH	National Institute for Occupational Safety and Health
NPDES	National Pollutant Discharge Elimination System
NPL	National Priorities List
OSHA	Occupational Safety and Health Administration
PCB	Polychlorinated biphenyl
PRP	Potential responsible party
RCRA	Resource Conservation and Recovery Act
SARA	Superfund Amendments and Reauthorization Act
SIP	State implementation plan
TSCA	Toxic Substances Control Act

A key RCRA objective was to identify those industrial wastes with characteristics that make them of special environmental concern; these characteristics include ignitability, corrosivity, reactivity, and toxicity (3). These wastes are defined as "hazardous waste" under Subtitle C of RCRA and are subject to a "cradle-to-grave" approach for management, which is designed to track their generation and transportation and to ensure their safe treatment, storage, and disposal through state and federal permit requirements. RCRA also addresses underground storage tanks used for petroleum and other dangerous substances to meet strict design specifications to minimize the risk of leaks.

As waste management legislation, RCRA encourages recycling. According to EPA, recycling of hazardous waste increased between 1989 and 1991. Overall, waste going to recovery processes more than doubled, with the greatest changes coming from recovery of solvents, highly toxic chemicals commonly linked to past pollution of surface water and groundwater (3).

Under RCRA, EPA is authorized to seek civil and criminal penalties of substantial magnitude. More importantly, from a public health and environmental standpoint, EPA is also empowered under RCRA to sue for or to issue an administrative order for a corrective action that would alleviate "imminent and substantial endangerment" to health or the environment (2).

The Comprehensive Environmental Response, Compensation, and Liability Act

The far better known companion statute to RCRA in the toxic disposal remediation field is the Comprehensive Environmental Response, Compensation, and Liability Act (CERCLA) of 1980. This law, more commonly known as "Superfund," created a mechanism to clean up abandoned hazardous waste sites across the country, removing harmful materials dumped improperly

into the environment over past years. Funded by the responsible companies (potential responsible parties [PRPs]) as well as by taxes on petroleum and chemical production, EPA manages cleanups at Superfund sites (2).

Under CERCLA, EPA is empowered to undertake cleanups itself, using Superfund money, and to seek reimbursement from PRPs; to issue administrative orders to potential responsible parties directing them to undertake cleanups; to seek court orders directing potential responsible parties to undertake cleanups; or to use a combination of approaches.

The EPA under CERCLA ranks Superfund sites according to the risk posed to human health and the environment, and places the worst sites on the National Priorities List (NPL) to ensure that the most dangerous sites are remediated first. CERCLA requires EPA to establish a national contingency plan that is, in essence, a compendium of the standards and procedures for cleanups that will insure an acceptable result (2). Under CERCLA, the Agency for Toxic Substances and Disease Registry (ATSDR) was created also. Among other activities and responsibilities, ATSDR produces case studies in environmental medicine that offer health care providers useful information regarding numerous hazardous substances. ATSDR offers support also to the Association of Occupational and Environmental Clinics (AOEC), a nationwide group of clinics providing patient evaluation for environmental exposure. Presently, there are 2 such clinic locations in Texas, at Tyler and Houston.

The Toxic Substances Control Act

The Toxic Substances Control Act (TSCA) of 1976 is directed to the chemical manufacturing industry. TSCA addresses the need to evaluate completely the potential toxicity and environmental impact of existing and new chemicals.

First and foremost, TSCA is designed to ensure that manufacturers test to identify hazards to human health and the environment associated with chemical substances before they are permitted to be manufactured and sold. Testing and disclosure of test results to the government are required whenever EPA publishes a test rule requirement. The statute operates like a permit system in that EPA can act upon adverse test results to prohibit or limit the manufacture or use of a chemical substance.

In 1977, EPA published its initial inventory of chemical substances. Any chemicals not listed were considered new chemicals subject to premanufacture review as of July 1, 1979. As new chemicals complete premanufacturing review and begin to be produced, they are added to the inventory. If a chemical is not already listed on the inventory, a premanufacture notification must be submitted. A manufacturer or importer must notify the EPA office of toxic substances 90 days before producing or importing a new chemical substance; upon review, EPA either approves production or importation of the chemical or acts to ban or otherwise restrict manufacture or use.

Title I of TSCA also included a provision requiring EPA to take specific steps to control the risk for polychlorinated biphenyls (PCBs), a substance commonly used in electrical transformers. Three titles have been added to TSCA to address concerns about other specific toxic substances, including asbestos, radon, and lead (5).

Title II of TSCA, the Asbestos Hazard Emergency Response Act, was enacted in 1986 and it required EPA to set standards for responding to the presence of asbestos in schools. The standard set responses based on the physical condition of asbestos, and schools were required to inspect for asbestos-containing materials (ACM) and to develop a management plan for such materials. Title II also requires people to be certified for asbestos work in school buildings. The title was amended later to extend training and accreditation requirements to include inspectors, supervisors, contractors, project designers, and workers performing asbestos abatement work in all public, industrial, and commercial buildings (5).

In 1988, Title III, addressing indoor radon abatement, was added to TSCA. The basic purpose of the amendment is to provide financial and technical assistance to states that support radon monitoring and control. The title required EPA to update its pamphlet on radon, develop model construction standards and techniques for controlling radon levels in new buildings, and provide technical assistance to the states (5).

Title IV of TSCA, the Residential Lead-based Paint Hazard Reduction Act, was enacted in 1992. This law aims to stimulate development of lead inspection and hazard abatement services in the private sector with the purpose of reducing the risk to young children who are exposed to lead-based paint in their homes (5).

The Federal Insecticide, Fungicide, and Rodenticide Act

The Federal Insecticide, Fungicide, and Rodenticide Act (FIFRA) requires any person distributing, selling, offering, or receiving any pesticide to register the poison with EPA. Under this act, EPA is required to grant registration for a pesticide once it determines that the pesticide is effective as claimed, that the labeling and other data supplied by the manufacturer conform to federal standards, and that the poison will perform its functions without unreasonable risk to humans and the environment. Granting registration takes into account the economic, social, and environmental costs and benefits of the pesticide's intended use and whether the pesticide will or will not cause unreasonable risk when applied in accordance with the directions for its use (2).

The Emergency Planning and Community Right to Know Act

This law, also referred to as Title III of the Superfund Amendments and Reauthorization Act (SARA), requires states to establish statewide and local emergency response planning committees charged with developing emergency plans. An important provision of these plans is to identify facilities in the community that contain substantial amounts of hazardous materials and to

provide for emergency actions that should be taken in the event of a release of those substances, including giving notice to the affected public.

Covered facilities must submit copies of a list of all the chemicals for which Material Safety Data Sheets (MSDS) are required (under the Occupational Safety and Health Administration [OSHA]) to the State Emergency Response Commission, the local emergency planning committee, and the local fire department. Also, these facilities are required to submit emergency and hazardous chemical inventory forms to the same state and local authorities. Information on the maximum daily amounts and chemical locations (designated Tier I information) was to be submitted on or before March 1, 1988, and annually thereafter. The more detailed Tier II information is submitted upon request. Reportable quantities or reporting thresholds determine when a submittal is necessary.

The Occupational Safety and Health Act of 1970 and the Federal Mine Safety and Health Amendment Act of 1977

Although these 2 acts are not related directly to the environment, they set the standards for the protection of the environment and human health within the work place. The Occupational Safety and Health Act administered by OSHA sets general industry standards and a wide range of specific health and safety standards, focusing on working conditions.

Some of the key provisions of the Occupational Safety and Health Act follow:

- To assure that every employee has safe and healthful working conditions;
- To require employers to maintain accurate records of exposure to potentially toxic materials or harmful physical agents that are required, under the various safety and health standards, to be monitored or measured, and to inform employees of the monitoring results;
- To provide procedures for investigating alleged violations at the request of any employee or employee representative, issuing citations, and assessing monetary penalties against employers;
- To provide for establishment of new rules and regulations for new or anticipated hazards to health and safety;
- To establish a National Institute for Occupational Safety and Health (NIOSH), with the same rights of entry as those for an OSHA representative, to undertake health studies of alleged hazardous conditions, and to develop criteria to support revisions or recommendations to OSHA for new standards. NIOSH is administered under the Centers for Disease Control and Prevention (CDCP); and
- To provide funding to states that wish to establish state programs that are at least as effective as the federal program in providing safe and healthful employment. Twenty-five state plans exist currently.

The Federal Mine Safety and Health Act (MSHA) of 1977 repeals the Metal and Non-metallic Mine Safety Act and establishes a single law for mine safety and health for all mining operations under an amended Coal Mine Health and Safety Act of 1969. The provisions of MSHA parallel those of the Occupational Safety and Health Act but apply specifically to the mining industry. Included within the coverage of this act is the protection of miners from radiation hazards connected with the milling of certain radioactive materials. Mine construction activity on the surface is included in the scope of the act.

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Environmental health issues along the United States-Mexico border: an airshed in evolution

Elaine Mowinski Barron, MD

CME learning objectives

Upon completion of this article, participants should be able to define the role of physician involvement and the cooperative efforts among governments and communities in improving air quality; and to relate the activities of the Paso del Norte Air Quality Task Force — a binational consortium of business leaders, regulators, scientists, physicians, and elected officials — and its efforts to improve the air quality in El Paso.

The El Paso area represents a unique ecosystem with a transboundary airshed shared by 3 cities, 3 states, and 2 countries. That toxic air pollutants respect no borders is exemplified clearly in this federally designated nonattainment area. However, a combination of grassroots involvement and studies under way through the scientific community has led to evolving approaches directed at improving air quality and identifying its impact on human health. The involvement of physicians and cooperative efforts among governments and communities has and will be key in this continued effort.

Situated midway along the United States-Mexico border are El Paso, Tex, Sunland Park, NM, and Ciudad Juarez, Chihuahua, Mexico — 2 countries, 3 states, and 3 cities. The separation of these cities, the boundaries of these states, and this border are all defined by the Rio Grande River. Geographically, the Franklin Mountains to the north and the Sierra de Juarez Mountains to the south form a transboundary airshed (1). Toxic air pollutants gather within the airshed and create a so-called nonattainment area, which violates the National Ambient Air Quality Standards established by the US Environmental Protection Agency (EPA) (2). Texas has 4 nonattainment areas comprising more than half of the state's population — Dallas/Forth Worth, Beaumont/Port Arthur, El Paso, and Houston/Galveston/Brazoria (3).

In 1997, El Paso was the only area in Texas that did not meet federal standards for respirable particles (PM-10), carbon monoxide, and ground level ozone (3). These toxic air pollutants are of major concern because of their harmful effects on human health and the environment. Since 1970, the Federal Clean Air Act has provided the primary framework for regulation and reduction of harmful effects from air pollutants. The Clean Air Act called for significant reduction of airborne toxics and acid rain, and for reduction of the depletion of the stratospheric ozone layer caused by agents such as chlorofluorocarbons (2). Each of the US agencies responsible for control of air quality must work with city and county governments along with regional planning commissions to develop and enact a plan to clean up the air (4).

El Paso poses a unique challenge because the airshed is a binational, tristate, and trijurisdictional problem. To facilitate dialogue and action, the Paso del Norte Air Quality Task Force — a binational consortium of business leaders, regulators, scientists, physicians, and elected officials — was formed (5). EPA and its Mexican counterpart, along with the Environmental Defense Fund, facilitated the Paso del Norte Task Force by strengthening international governance of the common airshed. These entities assisted also in utilization of market forces to stimulate transboundary investment in air pollution abatement and to build effective local environmental leadership in pursuit of a long-term program to reduce air pollution.

Grassroots support led to the birth of a number of important programs aimed at these air quality issues. These include a binational vehicle inspection program, attempts to lower automobile body and paint shop emissions, a brickmakers program using alternative fuel for oven firing, a citywide oxy-

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genated fuel program, and efforts aimed at the reduction of open burning. Economic feasibility has been a prime consideration in the development of these alternate methods to reduce air toxicity to avoid jeopardizing employment in this high-poverty area.

The measurement of health effects from air toxics has been a key element. The task force designed a study with the aid of Physicians for Social Responsibility and The University of Texas-Houston School of Public Health. A 3-year retrospective study has been undertaken to examine the incidence of acute exacerbations of childhood asthma requiring emergency room visits or urgent care and to relate this incidence to levels of air toxicity. These research efforts have spanned the United States-Mexico border. Monitoring equipment has been standardized through ongoing cooperation. Measurements of respirable particulate matter, ozone, and carbon monoxide continue within the airshed. The task force strives to develop studies that relate the combined cumulative impact of air toxics and particulate matter to a number of other pulmonary conditions, such as irritant bronchitis, rhinitis, and interstitial fibrosis (6). Other environmental relationships begging investigation include endocrine disorders and autoimmune diseases, which occur in El Paso at high rates. The significance of particulate and ozone precursors requires further study as well.

The interest of physicians in their communities is critical to meaningful scientific study and attempts to document environmental and occupational influences on health. Through the efforts of local citizens, the Paso del Norte Air Quality Task Force has evolved and influenced the federal creation of the Binational Air Advisory Committee to the Air Work Group under the La Paz Agreement, an existing treaty between the United States and Mexico. We, the physicians of the El Paso County Medical Society, are committed to working closely with our citizens and businessmen to protect the health of our community and of Texas.

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Occupational asthma

Jack E. Farnham, MD, MPH

CME learning objectives

Upon completion of this article, participants should be able to describe occupational asthma, its risk factors, basic mechanisms, and etiologic agents; to name the three recognized phases of asthmatic response; to explain the evaluation process to establish if asthma is related to the workplace; and to identify the treatment goals for occupational asthma.

The seriousness of asthma in the general population has been recognized by increased prevalence, morbidity, and mortality rates in the past 20 years. The effects of occupational asthma on health and productivity in the workplace have been so deleterious that the Occupational Safety and Health Administration targeted 1995 as a crisis year for effective remediation.

Several risk factors have been identified, but all asthma is multifactorial. Inhaled chemical, physical, and microbiological agents in the form of dust, fumes, gases, and vapors may cause workplace asthma, which is mediated through pharmacologic, immunologic, or irritant mechanisms. Because of the complexity of these mechanisms after exposure to the offending agents, the clinical manifestations may be classed as immediate, delayed, or dual responses.

Evaluating causation and relationship to work requires a thorough history (including detailed job description), physical examination, and definitive studies to determine the presence of bronchospasm, bronchial hyperreactivity, atopy, work-relatedness, and presence of specific sensitization.

Goals of treatment for occupational asthma are to maintain pulmonary function as close to normal as possible, to maintain a normal lifestyle, and to prevent exacerbation. In occupational asthma, particularly, the patient (or the inciting cause, if known) should be removed from the offending environment as soon as possible. Specific treatment depends upon the specific offending agent, and antiasthma therapy may be needed following the guidelines of the National Heart, Lung, and Blood Institute.

Within the past century, the significance of asthma has escalated from Osler's opinion that a paroxysm is rarely fatal (1) to the realization that asthma is an extremely serious disease, with mortality as high as 17.9 per million in 1995. Asthma presents a dramatically changing picture, with an increase in prevalence, office visits, hospitalizations, and mortality rates for the 15-year period from 1980 to 1995.

The Centers for Disease Control and Prevention Asthma Surveillance Survey (1960–1995) (2) found that 13.7 million cases of asthma were self-reported in the United States alone in 1995, a 75% increase over 1980 data (Fig 1). Office visits increased 50% from 1975, emergency room visits were more than 1.8 million in 1995, and hospitalizations increased by 18% from 1979 through 1994. Mortality rates rose from 8.2 per million in 1977 to 17.9 per million in 1995, a 46% increase (Fig 2). Worldwide health statistics mirror these figures and indicate that this is a global phenomenon.

Why this increase in severity and mortality? No one knows for certain, but many theories abound: decrease in bacterial infections with corresponding increase in viral infections, increase in air pollution, difficulty in access to medical care for indigent cases, and masking of symptoms by newer medications. Whatever the cause, asthma is multifactorial in origin with familial, infectious, allergic, socioeconomic, psychosocial, and environmental factors underlying.

Asthma is, by definition, a chronic

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inflammatory disorder of airways, characterized by variable airflow obstruction and airway hyperresponsiveness (3). In most cases, asthma presents symptomatically with dyspnea, wheeze, tightness of chest, and cough.

Occupational asthma

The latest estimates from the US Department of Labor indicate that more than 65,000 workers are affected annually by occupational asthma, the prevalence being between 5% and 15%. This was associated with such a deleterious effect on health and productivity in the workplace that the Occupational Safety and Health Administration declared the year 1995 as a crisis year for occupational asthma.

Occupational asthma is caused by workplace dust, fumes, gases, or vapors. This disease may be either preexisting asthma, which is aggravated in the workplace, or new onset asthma, occurring after the worker has been exposed to causative agents in the workplace.

Irritants, immunologic sensitization, pharmacologic mechanisms, or a combination of all may cause occupational asthma. A single massive exposure to irritants may result in a specific subset of asthma, referred to as reactive airways dysfunction syndrome (RADS). This syndrome is a sudden onset of asthma in nonallergic workers who have no prior history of lung disease. Chronic, low-dose exposures to irritants might result in slowly developing but persistent irritant asthma. Both of these conditions have been described by Stuart Brooks, MD (4,5).

Workplace agents that can cause sensitization usually are latent for several weeks or months after the initial exposure before clinical asthma becomes apparent. During this latency period, the immune sensitization mechanism becomes activated through the actions of T- and B-lymphocytes, I_gE antibodies, and mast cells. Upon reexposure to the offending chemical, a clinically symptomatic reaction occurs following release of histamine, leukotrienes, prostaglandins, and kinins, causing acute bronchoconstriction, mucous membrane edema, and airway plugging.

Fig 1. Estimated average prevalence rates of self-reported asthma for persons aged 5 to 34 years, by region and year — United States, National Health Survey, 1980-1994.

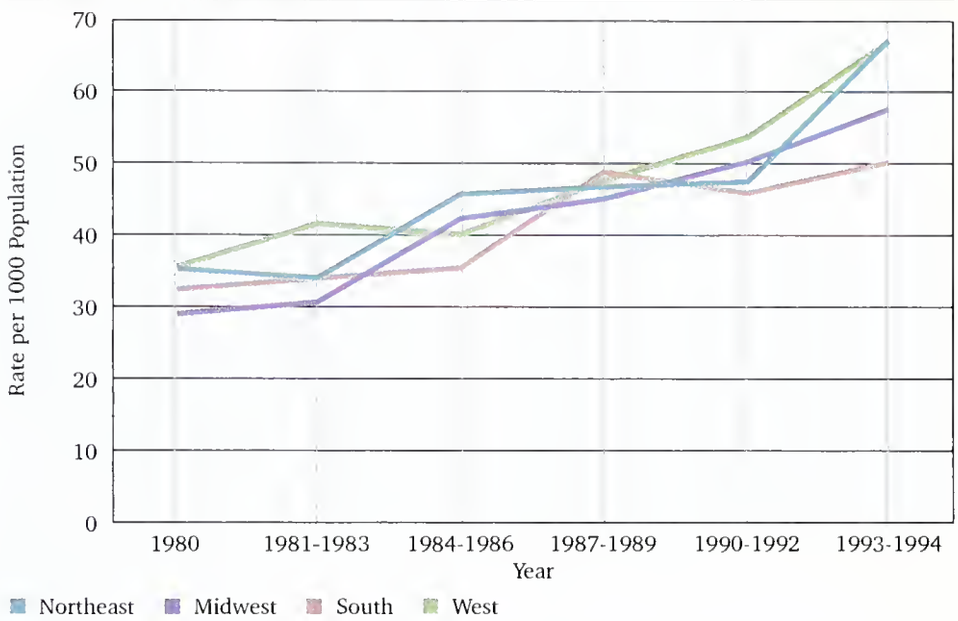
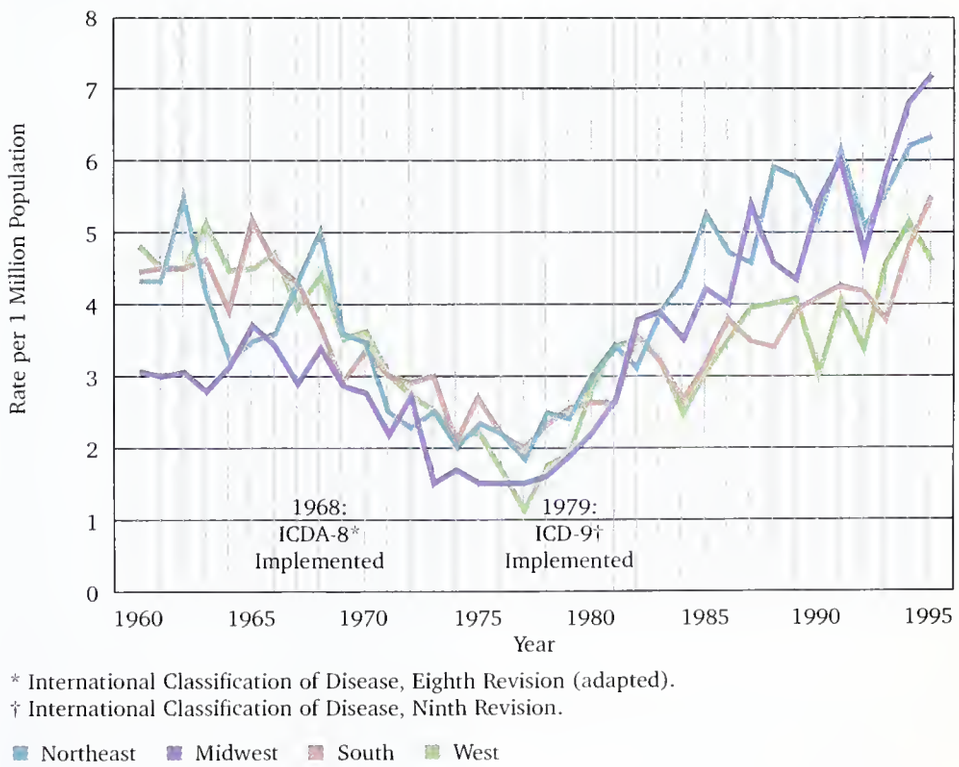


Fig 2. Rates of death for asthma as the underlying cause of death for persons aged 5 to 34 years, by region and year — United States, Underlying Cause of Death data set, 1960-1995.



* International Classification of Disease, Eighth Revision (adapted).
† International Classification of Disease, Ninth Revision.

Risk factors

Studies have indicated that several risk factors may predispose workers to occupational asthma, although this is somewhat controversial at present. One risk factor is *atopy* (the state of being allergic), which may predispose people to the immunologic mechanism of occupational asthma. Persons who are atopic usually have very high levels of I_gE anti-

Table 1. Some high molecular weight causes of occupational asthma.

Source	Antigens
Plant	Pollens, fungal spores, vegetable gums
Animal	Pelt, dander, saliva, urine
Foods	Flour, coffee beans, tea, castor beans, or aerosolized food particles

body and a specific HLA chain, both of which are inherited. Studies by Hagy and Settipane (6) have shown that asymptomatic college students with positive allergy tests followed over 7 years will demonstrate a 34% prevalence of asthma. In addition, 50% of allergic patients will have asymptomatic decreases in forced expiratory volume in 1 second (FEV_1). A second risk factor is a state of *hyperreactivity* of the bronchi in response to all types of irritating and sensitizing dusts, fumes, gases, and vapors.

A third significant risk factor is *cigarette smoking*. This behavior leads to inflammation of the bronchi, increasing the possibility of viral infections, which in turn lead to bronchial hyperactivity. Smoking also increases the level of I_gE antibody through unknown mechanisms.

Basic mechanisms

Occupational asthma may have an irritant, immunologic, or pharmacological pathogenesis. *Pharmacologic agents* are represented by 3 groups of chemicals: those causing direct *histamine release*, such as narcotics or cotton fibers; *anticholinesterase* chemicals, such as those found in insecticides (which cause asthma by increasing the concentration of acetylcholine); and *beta-adrenergic blocking* agents, such as toluene diisocyanate (which causes bronchoconstruction by blocking beta adrenergic receptors in the bronchi).

Immunologic agents causing asthma are antigens of either high or low molecular weight (above or below 40,000 daltons). The high molecular weight antigens usually involve the I_gE antibody mechanism and are found in materials from plants, animals, and food (Table 1). Low molecular weight antigens are mediated generally through the I_gG antibody-hapten complex (some through I_gE) and are often found in therapeutic agents such as antibiotics (penicillin, sulfonamides, cephalosporins, pharmacological methyldopa, and psyllium) and organic chemicals (isocyanates, acid anhydrides, plicatic acid, and colophony). Some organic chemicals (trimellitic anhydride) can cause multiple reactions in people through the I_gE and I_gG immune mechanisms, immune complex formation, and direct toxic damage. Another group of low molecular weight chemicals (eg, salts of chromium, cobalt, nickel, aluminum, platinum, and vanadium) causes asthma by mechanisms that are poorly understood. *Irritant reactions* (RADS and irritant asthma) have already been discussed.

Etiologic agents

Agents that can cause asthma may be either chemical, physical, or microbiological. As stated above, *chemical agents* may be of high molecular weight or low molecular weight. *Microbiological agents* are mostly high molecular weight. High molecular weight antigens will result usually in the formation of I_gE antibodies, whereas low molecular weight antigens are often related to antigen-protein hapten formation involving I_gG and I_gA antibodies. Fungi (high molecular weight agents in the microbiological category) can cause not only hypersensitivity reactions but also infection and toxicity. *Physical agents,* such as extremes in temperature (both high and low), low relative humidity, and particulate matter of less than 10 microns, can also cause occupational asthma.

Phases of asthmatic response

Because of the complex mechanisms involved in the causation and manifestations of asthma, the duration may vary between the offending exposure and the actual manifestation of asthmatic symptoms. Currently, we recognize 3 phases of asthmatic response: immediate, late isolated, and dual.

The *immediate phase* reaction occurs within seconds to minutes after exposure to the offending agent and is often caused by the release of histamine, prostaglandin, leukotrienes, or platelet-activating factors. Fifty percent of cases exposed to high molecular weight antigens will respond immediately, in contrast to only 10% of cases exposed to low molecular weight antigens (Fig 3).

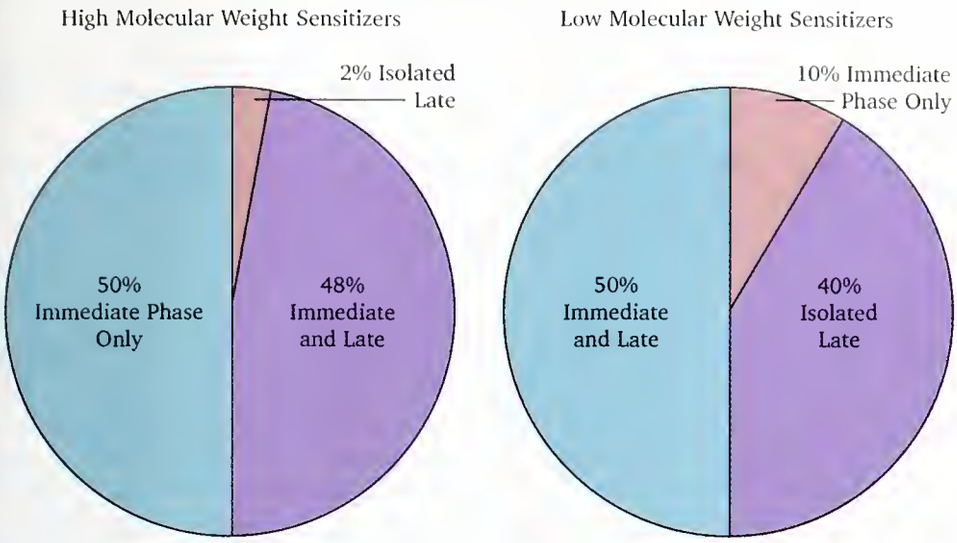
Late isolated responses usually occur within 6 to 8 hours after the initial exposure. These responses are usually caused by leukotriene release and influx of inflammatory cells. Low molecular weight antigen exposure is responsible for 40% of these isolated late reactions; only 2% result from exposure to high molecular weight antigens. These reactions often occur when the worker is at home or away from the worksite, thus causing much confusion as to the exact cause of the attack.

The *dual response* includes both immediate and late phase reactions. Dual response occurs with almost equal frequency (48% to 50%) in high molecular weight and low molecular weight antigenic exposure.

Evaluation

The purpose of a complete evaluation is to establish whether asthma indeed exists and, if so, whether it is related to the workplace. Initially, a general complete history with emphasis on allergy and occupational factors is extremely important. This history would include a review of the job description and the Material Safety Data Sheets, if available. A complete physical examination and routine laboratory workup are necessary to rule out any underlying diseases. Becklake presents a logical, stepwise workup to ascertain criteria for the presence of an asthma, allergy, and workplace relationship (7).

Fig 3. Patterns of inhalation challenge.



To establish the presence of *bronchospasm*, the clinician must be given a history of dyspnea, wheeze, and cough. Physical examination revealing wheezing is ideal, but often this is not present because asthmatics may be completely asymptomatic during the office evaluation. Pulmonary function tests at this point should show a decrease in FEV_1 and, perhaps, a decrease in forced expiratory flow 25%–75%.

To establish the presence of *bronchial hyperresponsiveness*, a history of episodic dyspnea, wheeze, and cough is needed. If baseline spirometry demonstrates an obstructive pattern, bronchodilator (such as albuterol) inhalation should show a 20% or greater increase in FEV_1. However, if the baseline spirometry is normal, a methacholine challenge test should result in a 20% drop in FEV_1. If no significant change occurs in the FEV_1 using these procedures, then no significant bronchial hyperresponsiveness exists.

To establish the presence of *atopy*, history should reveal an atopic family history or a history of previous allergies in the patient. More likely than not, skin tests to common antigens should be positive and radioallergosorbent testing may be helpful. Increased levels of total I_gE and elevated total eosinophil counts are likewise helpful in diagnosing allergies.

To establish the *work-relatedness* of airway obstruction, a history of relation of symptoms to work with cessation of symptoms when away from work is valuable. Pre- and postshift spirometry and daily peak flow rate (PFR) diaries both at work and at home are helpful. The PFR should be recorded before, during, and after work. The physician should stress to the patient the importance of keeping the PFR diary on holidays and vacations as well as documenting any change in pulmonary function that occurs away from work.

To establish the presence of *specific sensitization*, skin testing is sometimes possible in cases of high molecular weight agents. Skin tests, however, afford little or no value when low molecular weight agents are involved. At times, specific I_gE radioallergosorbent testing may be helpful for certain chemicals. Inhalation challenge testing using specific agents is considered the gold standard among all tests for occupational asthma. Specific inhalation challenge testing, however, should be carried out only under conditions of close medical supervision in a specially designed inhalation unit and with emergency care available.

An occupational inhalation challenge unit is in operation at the Occupational Allergy Clinic at The University of Texas Health Center at Tyler. Testing with toluene diisocyanate already is being done, with further chemical and antigen tests planned in the near future.

Treatment

The goals of treatment are the same for all types of asthma: to maintain pulmonary function as close to normal as possible, to maintain a normal lifestyle, and to prevent exacerbations.

In occupational asthma, more than any other type of asthma, the patient must be removed from the offending environment as soon as possible. With continued exposure to the offending agent, more and more bronchial damage develops, and irreversible changes occur in the airways. This damage appears to be related to duration and dose, further emphasizing the need for early removal from the workplace. Removal of the offending agent by process substitution measures may be possible, but this should not delay interruption of exposure. A respirator is not a suitable alternative in cases of allergy.

If occupational asthma symptoms are present during or after removal from the workplace, then pharmacological treatment of asthma as outlined by the National Heart, Lung, and Blood Institute guidelines is needed. Treatment is based on the classification of severity in 4 steps: mild intermittent asthma, mild persistent asthma, moderate persistent asthma, and severe persistent asthma. The specific recommendations for each step are detailed in these guidelines (8).

Summary

In summary, occupational asthma may have three main mechanisms. A detailed history, physical, and appropriate laboratory and pulmonary function tests will reveal the cause in many cases. Removal from exposure is the treatment of choice, and regular antiasthma therapy may be needed to control ongoing symptoms.

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The Texarkana mercury incident

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Jeffrey L. Levin, MD, MSPH
Stanley Collins, MD
W. Kent Anger, PhD

CME learning objectives

Upon completion of this article, participants should be able to summarize the report of a 1997 incident in which 2 teenagers removed a large amount of metallic mercury from an abandoned sign plant and distributed the materials among friends; to explain the investigations of the incident by the Arkansas Department of Health and the US Environmental Protection Agency; and to discuss laboratory results, medical evaluations, and neurobehavioral test results of the persons involved in the incident.

In November 1997, 2 teenagers allegedly removed a large amount of metallic mercury from an abandoned sign plant and distributed the material among friends. One teenager developed symptoms and admitted playing with mercury to his physician. His blood mercury was elevated. In February 1998, faculty from The University of Texas Health Center at Tyler conducted an investigation that included in-depth evaluations on 10 patients with urine mercury concentrations up to 100 μg/L. Exposure pathways and timelines were reconstructed from records assembled by the Arkansas State Health Department epidemiologist. Mercury contamination was found among teenagers, children, and adults who came in contact with the metal. Biomarkers of exposure documented reduction in mercury concentrations after these persons were removed from their homes and sources of mercury. Neurobehavioral assessment, including assessment of tremor, failed to establish a relationship between mercury exposure and performance.

Background

Mercury is a unique metal that has been used for thousands of years because it is a liquid at room temperature, expands and contracts in a predictable manner over a wide range of temperatures, and readily forms alloys (amalgams). In recent years, mercury has also been shown to conduct electricity and has been used in switches and batteries. The vapors of mercury give off light when electricity passes through them. Mercury vapor lamps provide the bluish hue from streetlights. Mercury compounds may be organic or inorganic salts. Compounds of mercury have been used as antiseptics, disinfectants, diuretics, explosives, paint pigments, and fungicides.

Unfortunately, mercury and its compounds are poisonous. That cinnabar, the ore from which mercury is mined, is responsible for a variety of health problems has been known for more than 2000 years. In ancient times, the monthly workshift of cinnabar miners in Almaden, Spain, was restricted to 8 shifts of 4 hours to reduce morbidity (1). In 1700, health problems were described among gilders and workers who manufactured mirrors using elemental mercury (2). In the 1800s, hatters who used acid nitrate of mercury developed erethism, with symptoms of depression, irritability, tremor, and cachexia (3). When mercurials were used to treat syphilis, salivation and blackened teeth were observed with therapeutic doses. In more recent years, outbreaks of organic mercury poisoning have been described among hundreds of people in Minamata Bay, Japan, as the result of industrial waste contamination (4). In Iraq, when grain treated with fungicide was used to make bread, 500 persons died and 6000 were hospitalized (5). In 1997, a scientist at Dartmouth died after cutaneous exposure to an organic mercury compound while at work. Two clusters of children and adults who were exposed to elemental mercury were reported recently (6,7).

This report summarizes a recent investigation of exposures to elemental mercury in a local community. Elemental mercury is regarded largely as a curiosity, and its toxic properties are not appreciated. The metal is poorly ab-

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sorbed through the skin or the gastrointestinal tract. The inhalation of mercury vapor is the most common source of mercury poisoning (8).

Mercury vapors are absorbed readily through the lungs. Acute high level exposure to mercury vapor will cause bronchial irritation and acute chemical pneumonitis. Deaths have been reported from respiratory failure. Gingivitis and stomatitis may develop several weeks after exposure. Those who recover from acute high-level exposure may have residual impairment of pulmonary function.

Mercury vapor exposure may cause irritability, diminished concentration, and memory impairment. Symptoms of depression, anxiety, insecurity, and decreased socialization may be present. Parkinsonian symptoms or a fine tremor of the extremities, tongue, and lips may develop. Patients may have a sensorimotor axonopathy of the peripheral nervous system, with the lower extremities being more affected than the upper extremities. Impairments of hearing and color vision along with concentric constriction of the visual fields have been reported also.

After absorption, the mercuric ion is excreted through the gastrointestinal tract and the kidneys by glomerular filtration and active secretion. Patients may develop acute tubular necrosis and uremia. Proteinurea, hematuria, and casts are manifestations of renal damage.

The incident

On December 18, 1997, a teenager visited his physician in Texarkana, Ark, because of a persistent cough, headaches, insomnia, cold feet, generalized aches and pains, and nausea. He had discomfort when he lay on his back. For 10 days, his mother had treated him with over-the-counter medications for "flu." When questioned by the doctor about unusual activities, the boy mentioned that he had been playing with mercury. A blood mercury test showed 104 μg/L, indicating excessive exposure. The physician then notified the Texarkana Hazmat Team about the exposure.

The Hazmat Team contacted the local Office of Emergency Services on December 31, 1997, and the event was reported to the Arkansas Department of Health (ADH). Between 23 and 100 pounds of mercury were estimated to have been removed by 2 teenagers from an abandoned neon sign plant. Twenty-one pounds of the metal were confiscated from an apartment occupied by the index case. The mercury was stored in glass jars placed in an aquarium outside the apartment. Other agencies subsequently notified included the Arkansas Department of Pollution Control and Ecology (ADPC&E) and the Environmental Protection Agency (EPA).

Investigations by the Arkansas Department of Health and EPA

EPA and ADH began their investigation January 2, 1998. ADH identified those persons who had been potentially exposed through personal interviews. These agencies analyzed the routes of exposure in the teenagers and determined if biomedical testing (blood/urine samples) or physician referral was indicated. ADH determined also the location of potentially contaminated residences and established evacuation criteria. Relocation of residents was required if the mercury vapor level in indoor ambient air exceeded 10 $\mu g/m^3$. EPA scheduled remediation for residences that were contaminated. Contaminated materials and furnishings were removed from many homes. Personal belongings from such residences (clothing, personal items, and shoes) and other property (vacuum cleaners, clothing, bedding, and throw rugs) were bagged, and the headspace in the bag was tested. If the mercury level was less than 10 $\mu g/m^3$, residents were allowed to retain the item, but if mercury levels were higher, the property was confiscated by EPA.

Reoccupancy criteria were established on the basis of ambient air mercury levels. EPA temporarily relocated residents living in contaminated homes and remediated the structures. Mercury had contaminated a school classroom, which also required remediation. EPA also removed additional hazardous substances from the neon sign plant.

ADH monitored ambient air levels in the remediated homes for 6 months to ensure that mercury levels remained below 0.3 $\mu g/m^3$. ADH advised all persons with elevated levels of mercury in their blood or urine (ie, greater than 20 μg/L) to consult with their personal physicians to determine what, if any, follow-up actions should be required.

Timeline and exposure pathways

During the 1997 Thanksgiving vacation, 2 teenagers allegedly removed a large amount (estimated 23 to 100 pounds) of elemental mercury from an abandoned neon sign plant site in Texarkana, Ark. The mercury was taken initially to an apartment occupied by 1 of the boys. Portions were then distributed to 2 other homes in the area and shared finally with persons from 10 more homes. Several teenagers wore contaminated clothing and shoes home after playing with mercury, and contamination of their homes resulted. Ultimately, elevated mercury levels were identified in 30 persons located in Texas and Arkansas, and in 12 residences, a convenience store, and a school classroom.

The mercury was removed from the plant on or about November 25, 1997. During the next 6 weeks, local teens experimented with "recreational use" of mercury. The teenagers thought that playing with mercury was "cool" and conducted "experiments" with the liquid metal. They described dipping their arms in the aquarium filled with mercury. They placed it on their clothing to watch it seep through their T-shirts in tiny droplets. They played "catch" with mercury by throwing the material back and forth and catching it in their T-shirts. They used it to coat jewelry and coins. They also "huffed" mercury (defined as heating mercury and inhaling the vapors), tried to burn the metal, dipped cigarettes into the mercury and smoked them, and poured the metal on the house steps and sidewalks. Ultimately, small containers of the material were sold to friends and acquaintances.

By New Year's Eve of 1997, ADH, ADPC&E, and EPA had been notified of the problem. On January 2, 1998, ADH

and EPA began investigating and remediating. From January 2 to January 9, 1998, homes were screened for mercury. The residents of homes found to be contaminated were relocated to a local hotel, and remediation was initiated. As knowledge of the exposure pathway expanded, more homes needed to be screened. Most of the remediation was completed between January 17 and January 23, 1998, but 1 home was not cleared for 3 months. Two structures could not be cleared. Demolition of 1 home and the apartment of the index case was necessary. In other contaminated homes, mercury levels were lowered by removal of floors, crawl space dirt, or wallboard as necessary.

Blood and urine specimens were collected from 61 persons by ADH or by personal physicians from January 5 to January 13, 1998. The Poison Control Center advised that patients whose blood levels exceeded 30 μg/L be notified by phone of the results, and these patients were advised to consult with their physicians to determine the need for treatment.

Guidelines for acceptable levels of mercury in urine and blood are shown in Table 1 (9,10). Note the dependence of fish consumption on blood mercury levels.

Limits for mercury concentrations in blood and urine were developed primarily by organizations focusing on occupational exposures (9,11–13). These are listed in Table 2. Please note that these guidelines delineate action levels, rather than toxicity, indicating that continued exposure could lead to symptoms and adverse health effects.

Table 1. Mercury levels in reference populations.

Mercury in Urine (μg/g Creatinine)	Mercury in Blood (μg/L)	Comments
Less than 5 (< 5 μg/L)	2	No fish consumption
	4.8	< 2 fish meals per week
	8.4	2-4 fish meals per week
	44.4	> 4 fish meals per week

Note: Urinary mercury is not affected by fish consumption.

Table 2. Guidance values for mercury in blood and urine. These values indicate action levels but not toxicity.

Mercury in Urine (μg/g Creatinine)	Mercury in Blood (μg/L)	Reference No.
35	15	11
50	> 20	12
50	No value	9
No value	18	13

Laboratory results

Sixty-one subjects provided blood and/or urine specimens in January 1998. Retests were offered when mercury levels in blood or urine exceeded 20 μg/L, and 13 of 20 persons eligible for the retest accepted. Summary results for those with paired blood and urine are shown in Table 3. Results for urinary mercury are presented as μg/L of urine and as μg/g of creatinine excreted. Most of the elevated data shown as μg/L of urine are the result of concentrated urine specimens. The results expressed as μg mercury per gram creatinine reflect mercury exposure more accurately and should be compared with mercury values for blood.

Some patients were advised by the Arkansas Poison Control Center to seek medical attention from their doctors; Succimer, an oral orphan drug approved for use in lead poisoning, was ultimately prescribed for 5 patients by their treating physicians. Two of the 5 patients filled their prescriptions: 1 patient took a single dose; the other, several doses before discontinuing the medication after experiencing side effects.

On February 7, 1998, repeat blood and urine tests were offered to all whose initial mercury levels in blood or urine exceeded 20 μg/L. Blood mercury values collected in February were much lower than those collected in January. This was thought to be the result of removing subjects from sources of exposure. Most, but not all, of the urinary data expressed as μg mercury per gram creatinine showed reduced levels, reflecting the biological half-life of mercury in urine of about 40 days (8). Subjects with persistent elevations were suspected of having continued exposure. Higher levels of urinary mercury in the index case suggested elimination of mercury as a result of chelation with Succimer; a concomitant fall in blood mercury is consistent with this hypothesis.

Medical evaluation summary

Individuals were examined initially by different physicians from different facilities. No summary of medical findings on the exposed population seen during December and January is available. In February, all persons with exposure to elemental mercury who were identified to have blood or urine mercury levels exceeding 20 μg/L were offered the opportunity to be screened by a community family practitioner and an occupational physician from The University of Texas Health Center at Tyler, and also to be evaluated by a neurobehavioral team from Oregon Health Sciences University.

Several of these people admitted to concomitant exposure to alcohol and/or illegal drug use (predominantly marijuana and some cocaine). Two persons reported irritability, and 1 complained of fatigue. One patient had a cough but had been diagnosed with varicella pneumonia shortly after exposure to mercury. This patient also had numbness in a single lower extremity. These symptoms were not considered related to mercury exposure. One patient reported decreased near vision, but this was thought to represent presbyopia. Two of the 9 patients examined were noted to have a barely perceptible tremor, which did not interfere with handwriting or drawing. One of these patients, with a slight tremor of intent, reported that his tremor was present "all of my life"; this tremor was not considered to be related to mercury exposure. No other neurologic abnormalities were noted. No patients had pulmonary or renal symptoms or signs. Because of the paucity of signs and symptoms of adverse effects and the normalization of urine mercury levels, none of the persons examined were advised to have additional follow-up.

Table 3. Summary blood and urine mercury concentrations for subjects with paired data collected in January and February 1998.

Person ID	Date Collected	Blood Hg (μg/L)	Urine Hg (μg/L)	Creatinine (mg/L)	Urine Hg (μg/g Creatinine)
3	1/2/98	31.0			
	1/7/98		110	3006	36.6
Index Case	12/18/97	104.0	36	1820	19.0
	2/6/98	7.2	160	2391	66.9
9-B	1/9/98	9.8	30	2261	13.3
	2/7/98	3.3	18	1271	13.9
10	1/8/98	21.0	29	1541	18.9
	2/7/98	4.4	25	1306	19.1
11-A	1/7/98	28.0	110	3570	30.8
	2/7/98	4.6	24	1439	16.7
11-C	1/7/98	17.0	76	2885	26.3
	2/7/98	4.0	17	1143	14.1
16	1/8/98	16.0	48	2728	17.6
	2/7/98	ND	55	3754	14.6
20	1/5/98	12.0			
	1/7/98		66	2300	28.7
23	1/8/98	3.6	30	2981	10.1
	2/7/98	ND	14	1904	7.4
29-B	1/6/98	35.0	24	1450	16.0
	2/7/98	5.6	20	1134	16.9
29-C	1/6/98	26.0	27	1690	15.0
	2/7/98	ND	39	2533	15.4
35	1/13/98	5.0	21	3548	5.9
	2/7/98	ND	15	2897	5.2
38-A	1/7/98	100.0	51	766	66.6
	2/7/98	10.0	53	1202	41.3
38-C	1/7/98	79.0	100	1456	68.7
	2/7/98	9.2	120	2183	55.0
38-D	1/7/98	51.0	77	1246	61.8
	2/7/98	7.5	36	1073	33.6

ND = no data

Neurobehavioral testing

A battery of neurobehavioral tests was selected to assess the effects of mercury exposure reported in the literature and to provide background on the psychological functioning of the Texarkana residents tested. The Beck Depression and Anxiety Inventories and the SF-36 were administered as part of the computerized Health Screening System (14). The Symbol-Digit, Digit Span, Tapping, Simple Reaction Time, Serial Digit Learning, and Oregon Dual Task Performance tests were administered as part of the computerized Behavioral Assessment and Research System (15). The Wide Range Achievement Test III was administered to assess educational levels (16).

Summary of neurobehavioral results

Neurobehavioral and psychological tests were administered to 12 patients, 8 of whom were exposed to mercury and 4 who were controls. All but 1 of the 8 exposed participants were reported to have urine mercury concentrations below the range that has been associated with adverse effects in the research literature on inorganic and elemental mercury. Although mercury-exposed participants generally demonstrated poorer performance on neurobehavioral tests than controls, average or better test results for educational attainment and reading skills for the controls contrasted with results below expectation for educational attainment and/or reading skills for most of the mercury-exposed participants. This suggests that, as a group, the mercury-exposed participant's neurocog-

nitive ability before the exposure was below average.

Because most participants had urine mercury concentrations below the range previously associated with adverse effects, pre-exposure ability level is a more likely explanation than neurotoxic exposure for the poorer performance on neurobehavioral tests of mercury-exposed participants as compared with that of the controls. Two other findings support this hypothesis: first, positive rather than negative correlations were found between urine mercury and neurobehavioral test performance, which is contrary to expectation if mercury exposure had contributed to the performance deficits; and second, the 1 mercury-exposed person with a urine mercury concentration in the range associated with neurobehavioral performance deficits reported in the literature had fewer performance deficits than most other mercury-exposed participants. All but 1 of these persons were within normal limits on measures of anxiety and depressive symptoms, and no consistent pattern associating measures of perceived health with mercury exposure was noted. In addition, the responses of 1 mercury-exposed person raise concerns that this person was not fully motivated to perform the neurobehavioral tests. The questionnaire results of another mercury-exposed person revealed symptoms suggestive of clinical depression.

Educational event

Faculty from The University of Texas Health Center at Tyler discussed the history, major health effects (including neurobehavioral), diagnosis, guidelines for biomonitoring, and treatment for elemental mercury exposure with a group of 25 medical residents and local physicians. Biomonitoring, the kinetics of elimination, quality assurance of testing laboratories, and guidelines for interpretation were reviewed. Unfortunately, no consensus guidelines exist for institution of chelation. Patients must be treated on the basis of clinical signs in conjunction with appropriate laboratory data. As a general recommendation, persons with blood levels higher than 100 μg/L and urine levels higher than 100 μg/g creatinine, accompanied by signs of mercury toxicity, should receive treatment.

Recommended follow-up

On the basis of the urine and blood data from January and February, as well as the medical and neurological examinations conducted on February 19, 1998, no medical follow-up was recommended. Two families caused some concern. Both were contacted but refused to participate in follow-up urine/blood testing or medical evaluation. One family showed elevated levels of urine mercury in the February 7, 1998, screening, and concerns were raised about possible continuing exposure. This fear was alleviated, however, by a mercury screening of the residence in late March, which confirmed that the residence was "cleared" and that continued exposure from the residence was not an issue.

The index case did not return for his medical/neurological examination scheduled for February 19, 1998. On the basis of the data from other exposed persons and on the general finding of successful household remediation, no follow-up was recommended.

In both of these cases that caused concern, levels of mercury in blood and/or urine are expected to decline according to the elimination half-lives of about 40 days. If continued exposure is no longer a possibility, mercury levels in blood and urine should continue to fall. The affected persons are fully aware of the toxicity of mercury, if not from communication with medical professionals, then from conversation with peers and media presentations.

Discussion

Despite the rather chaotic nature of community exposures, local and state officials were very effective in the emergency response to this incident. EPA was requested promptly to aid in cleanup. Affected families were immediately removed from continuing mercury exposure. This is the best way to reduce the potential for serious, long-term consequences of mercury exposure.

Aside from the poison control center, local health officials frequently do not have a plan to deal with toxic emergencies. State agencies are not often staffed with medical toxicologists, biomonitoring experts, or occupational/environmental medicine specialists who can help provide information in occupational or environmental chemical emergencies. In the Texarkana event, local physicians contacted the state health department, received information on mercury hazards, and aggressive medical treatment was recommended.

Physicians interested in hazardous exposures may benefit from a series of case studies or a variety of other materials developed by the Agency for Toxic Substances and Disease Registry (ATSDR), an agency of the Public Health Service (16,17). These materials are available without charge from that office, and some have been approved for Category 1 continuing medical education credit (18). Further information can be obtained by writing to ATSDR, 1600 Clifton Rd NE, Atlanta, GA 30333. The Association of Occupational and Environmental Clinics and ATSDR are 2 organizations that serve as clearinghouses for health professionals and can provide assistance in most toxic emergencies. In the event of a chemical spill or other toxic emergency, the dissemination of accurate, reliable information can make the difference between an annoyance and a disaster.

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Commentary

The silent voice of reason

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Glenn Phillips, MS, ChE

CME learning objectives

Upon completion of this article, participants should be able to recognize the need for scientists to more effectively communicate environmental health science to the public and to become more active in the arena of environmental health risk communication; to present significant facts related to environmental health issues and regulations; to improve the effectiveness of their communication of environmental risks; and to use risk comparisons as an effective tool for communicating risk perspectives.

In the arena of environmental health science, we need more data, and we must better interpret the information we have already. Perhaps our greatest deficit, however, lies in the need to communicate more effectively with the public on matters of environmental health science. At the heart of better environmental health, we believe, is a critical need for scientists to become more active in communicating environmental risks.

Introduction

As we approach the end of the "Decade of the Environment," reflection is appropriate: where are we, and where we are going in our pursuit of a cleaner environment? In many respects, our environment is better today than 10 years ago or 110 years ago. Taking a drink of water no longer poses a mortal risk of cholera. Garbage is no longer thrown outside for free-running animals to scavenge. Automobiles have replaced horses, which had left our streets full of manure, stench, and disease.

Dramatic environmental improvements have been made. Yet the realization is increasing that we often are not spending our environmental dollars wisely. We believe the major reason for this inefficiency is not lack of data but poor and ineffective communication of probabilistic risk from scientists to the public. The concept of costs versus benefits associated with environmental improvements, in particular, has not been presented well.

A report from the Harvard School of Public Health's Center for Risk Analysis has estimated that an additional 60,000 lives per year could be saved simply by reallocating $21.4 billion annually (about one seventh of our cost for environmental controls) to more cost-effective life interventions. Or, alternatively, the current number of lives could be saved with a $31.4 billion annual expenditure reduction simply by investing the remaining resources in lifesaving interventions costing less than $16,500 per life saved (1). Environmental health regulatory policies that ignore risk assessment, prioritization, and cost-effectiveness tend to drift toward overfocus on trivial risks, ultimately leading to wasted resources and loss of lives (1–3).

Table 1 shows a sampling of the wide disparity in cost of various life interventions (4). Americans tend to spend enormous amounts of money on cost-ineffective activities, such as excessive cleanup of Superfund sites, while ignoring more effective opportunities, such as flu shots, highway improvements, or reduction in smoking (4).

We believe environmental health science has 3 opportunities for major improvement: first, better data generated through more research; second, better interpretation of data with more realistic animal testing methodologies for carcinogenic risk and cancer rankings; and third, better risk communication with the public to improve the societal perception of risks versus benefits.

Typically, environmental health scientists trumpet the first opportunity, debate the second, and dutifully avoid the third. This prioritization sometimes serves us well. Thus, for a person facing heart bypass surgery, understanding a 5% mortality risk is relatively simple, and opportunities for improvement lie clearly in more research.

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Table 1. Lifesaving costs (median cost of a year of life saved by various interventions [4]).

	Cost, in dollars
Childhood immunization	Less than zero
Prenatal care	Less than zero
Flu shots	600
Water chlorination	4,000
Cholesterol screening for boys at age 10 years	6,500
Cervical cancer screening for women older than 60 years	11,000
Pneumonia vaccination	12,000
Breast cancer screening	17,000
Construction safety rules	38,000
Kidney dialysis	46,000
Heart transplant	104,000
Cervical cancer screening for women older than 20 years	224,000
Preventing industrial releases of carcinogenic emissions	2,500,000
Seat belts in school buses	2,800,000
Preventing chloroform releases from pulp mills	99,000,000,000

Table 2. Approximate oral LD50* in rats for a group of well-known chemicals (33).

Chemical	LD50 (mg/kg)	Relative Toxicity
Sucrose (table sugar)	29,700	1
Ethyl alcohol	14,000	2
Sodium chloride (common salt)	3,000	10
Vitamin A	2,000	15
Vanillin	1,580	19
Aspirin	1,000	30
Chloroform	800	37
Copper sulfate	300	99
Caffeine	192	155
Phenobarbital, sodium salt	162	183
DDT	113	263
Sodium nitrite	85	349
Nicotine	53	560
Aflatoxin B1	7	4,243
Sodium cyanide	6.4	4,641
Strychnine	2.5	11,880

* LD50 is the lethal dose for 50% of the rats.
DDT = dichlorodiphenyltrichloroethane

As for chronic environmental risk, however, we believe the above prioritization should be reversed. Thirty years ago, many of our environmental improvements were identified easily because they simply made good sense. Today, however, as regulatory constraints become increasingly restrictive and costly, we must move from good sense to good science. When a regulatory agency considers reducing the ozone standard from 0.12 to 0.08 parts per million (ppm), or a manufacturing facility contemplates a $50 million expenditure to reduce emissions of ethylene, more data are needed, but often the greater need challenges us to better interpret the data we have and to explain that interpretation more effectively to the public. Otherwise, public policy will likely be driven by "sound bites" instead of sound science. We need to improve interpretation of environmental toxicology research, and we need to communicate those results more effectively to the public.

Researchers at the Harvard Center for Risk Analysis, Dr Elizabeth Anderson, former head of the Environmental Protection Agency (EPA) Cancer Assessment Group, Dr Bruce Ames of the University of California at Berkeley, and numerous other researchers have stated that we are greatly exaggerating carcinogenic risk by opting to err on the safe side at each step of our toxicological methodologies (5–14). Richard Belzer, risk specialist with the US Office of Management and Budget, estimates risks interpreted from animal studies are 100 to 5000 times overstated (15). Linear extrapolation to zero (no threshold) has overstated leukemia risk from benzene (16). Studies by Dr Sandra Archibald of the Food Research Institute at Stanford University and Carl Winter at the University of California, Riverside, show that extreme assumptions have overstated risks from tomatoes (2600 times), from apples (21,000 times), and from lettuce (300 times) (17-19). (For a scholarly presentation on how conservative risk assessment methodologies distort regulation, we recommend "The Perils of Prudence" [20].)

Perhaps our biggest challenge for improving environmental health regulations is communicating probabilistic risk with the public in a clear, honest, and understandable manner. The environmental health concept of "risk versus benefit" must be a focus of this communication. That is, what are the costs of an environmental action (or inaction) compared with the benefits? This commonly leads to the classical tension: should we "produce until proven *unsafe*" or "ban until proven *safe*"? Society will normally opt for a decision somewhere between these two extremes — always based on incomplete and imperfect data.

How we separate real environmental health risks (which do exist) from the imaginary and exaggerated ones (which exist also) — how we weight and ultimately control them — is an increasingly critical issue facing our nation. We must recognize that ultimately the public will make this delineation. We need more research, and we need

more realistic application of research data, but ultimately the communication of that data to the public is what will lead to better regulations.

Tips for communicating risk

The skills and precautions related to risk communication have been widely reported (21,22). The public can understand and will appreciate an honest presentation of significant facts related to environmental health issues and regulations. For example, consider the following:

- Total cancer mortality rates (age-adjusted) are generally not increasing when the effects of smoking are discounted (23–29).
- Environmental pollution accounts for no more than 2% (30) and probably less than 0.5% of cancer mortality (31,32).
- At high enough dosage, all chemicals, natural and man-made, are toxic. Table 2 presents a relative ranking of toxicity for some common substances. Water, sunshine, oxygen, herbs, and vitamins can be toxic at levels of high exposure (33–40).
- Chemical plant workers live longer than the average. (They should, because the industry hires healthier-than-average employees and they receive better-than-average medical care [41].)
- Americans are living longer and healthier than at any time in their history. Life expectancy in the United States has increased from 47 to 76 years since 1900, and it has increased dramatically throughout the world (42–45).
- Cancer mortality rates (age-adjusted) in the United States are about average compared with the rest of the world (29).

Table 3. Lifetime mortality risk.*

Daily Dose	Mortality per Million	Carcinogen
EPA acceptable risk	1	
One chest x-ray (lifetime)	1	
Pesticide (all)	4	Includes PCB, EDB, DDT, and others
Tap water	5	Chloroform
Lightning strike (lifetime)	35	
Bacon	45	Nitrosamines
Herb (comfrey) tea	150	Comfrey, symphytine
Peanut butter	150	Aflatoxin
Diet cola	300	Saccharin
Raw mushroom	500	Hydrazines
Beer	14,000	Ethanol
Wine	23,500	Ethanol
Sleeping pill	80,000	Phenobarbital
Cigarettes	400,000	Numerous

* For example, the risk of death from 1 pack of cigarettes per day is 100,000 times greater than that from all pesticide residues combined. A typical regulatory risk level of 1 in a million is 35 times more protective than the risk of death by lightning.

Sources: Ames (49), Stroup (50), Gold (51), Wilson (65), Crouch (66), and Slovic (67).

PCB = polychlorinated byphenyls
EDB = ethylene dibromide
DDT = 1,1,1-trichloro-2,2-bis(4-chlorophenyl)ethane

Table 4. Lifetime mortality risk of 1 in a million (common regulatory acceptable risk level).*

1 chest x-ray
1 diet cola every 10 months
1 sleeping pill every 219 years
1 cigarette every 50 years
1 raw mushroom every 20 months
1 wine every 60 years
1 beer every 38 years
1 charcoal-broiled steak every 8 months
1 peanut butter sandwich every 5 months
1 cup comfrey herb tea every 5 months
3 hours in a coal mine
6 minutes in a canoe
10 miles on a bicycle
300 miles by car
1,000 miles by commercial aircraft
Being hit by a train

* Lightning kills 35 in a million.

Sources: Ames (48), Stroup (50), Gold (51), Wilson (65), Crouch (66), and Slovic (67).

To improve effectiveness of communication, we make the following suggestions:

Communication must precede the acronym. Effective communication can only take place in an atmosphere of trust and respect. Achieving effective dialog is extremely difficult after the "HELP," "STOP," and "SAVE" organizations have been formed. Or, as Peter Sandman of Rutgers says, "It's hard to talk to folks when they are throwing rocks at your car."

Communication flows 2 ways. How you listen may be more important than what you say.

Be honest. Room exists for honest debate but not for dishonesty. Trust does not mean agreement; trust comes from a perception of honesty. A dubi-

Table 5. Lifetime mortality risks (number of deaths per million).

Struck by train	1
Cancer per chest x-ray	1
Struck on ground by crashing airplane	4
Playing high school football	8
Struck by lightning	35
Drowning in home bathtub	100
Electric shock	350
Home accidents (all)	8,400
Vehicle accidents	14,900
Police work	15,400
Coal mining	58,800
Smoking	400,000

Sources: Stroup (50), Wilson (65), Crouch (66), Slovic (67), Tierney (36), and Environmental Protection Agency (33).

Table 6. Cancer mortality risk (based on a 24% background cancer mortality rate).

Risk Level	Mortality Increase	% Mortality Increase	Risk Comparison
1/10	2.4 → 3.4	42	1 cigarette/day
1/100	24 → 25	4.2	1 beer/day
1/1,000	240 → 241	0.42	2 mushrooms/day
1/10,000	2,400 → 2401	0.042	2 diet colas/week
1/100,000	24,000 → 24,001	0.0042	1 hour in a canoe
1/1,000,000	240,000 → 240,001	0.00042	1 sleeping pill/219 years

ous, even hostile, audience will respect an honest communicator.

The public rules. The scientist's role is never to impose levels of acceptable risk. The scientist can enlighten and inform, and the more informed people are, the better decisions they can make. But, ultimately, society does (and should) define acceptable risk levels.

Address the reasonable majority. Focus on the reasonable, though dubious, many, rather than on the irrational, though vocal, few.

Never exaggerate. No company is ever "doing everything possible" or "all we can," and no one can say, "it is safe."

Never claim a goal of "zero" risk, emissions, or accidents. "Zero" is not only unachievable but should not even be pursued; and, with care, we should not be afraid to say so. Dishonest "zero" risk thinking is revealed by expressions such as "clean as possible," "pure as possible," "safe as possible," and "we can't take chances with our children's lives." We must take chances with our children's lives; otherwise, we would never put them on a school bus or give them a Sabin polio vaccine, which *causes* an average of 10 cases of polio a year in the United States (46,47). Following the Value Jet crash in Florida, a safety expert stated we can never have enough safety equipment on an airplane. Carried to an extreme, this might lead to extremely high ticket prices, which, in turn, would lead to more travel by automobile, thereby resulting in an increased mortality risk.

We should all support actions and regulations that properly reduce risks. But extreme aversion to risk is harmful. Those societies that have taken risks have provided the greatest safety and health for their people. Perhaps Aaron Wildavsky of The University of California said it best: "If we hinder progress on the grounds it brings some bads, we will deny ourselves even greater goods. If it seems too cruel to contemplate any harm at all, the even greater cruelty is to abandon net benefit, for giving *that* up guarantees that more people will have worse health" (19).

Tiptoe through the experts. Environmental health issues have become greatly polarized and politicized. The use of "experts" and "consultants" can appear to be self-serving and may unnecessarily heighten outrage. In addition to being experts, consultants must be skillful and empathetic communicators.

Be "cool." Never express anger, frustration, or impatience. If necessary, defer getting your message across to another day. If you are shouted down, the audience will know who was treated unfairly.

Be simple and humble. Let the audience recognize your knowledge and expertise — you need not do it for them. To paraphrase a Proverb, "Let the audience praise you, and not you yourself" (48). "Sound science" is appropriate, but arrogance is deadly.

Be open to feedback. Feedback is essential, even if spiked with hostility. Anger well received usually becomes anger defused.

Admit, "I don't know." We should be confident of that which we do know. If we don't know the answer to a question, we should say so, with intent to find out. The audience must perceive that we are not being evasive, uncertain, or equivocal.

Address uncertainties of science. Audiences want answers and tend to think in dichotomies (eg, is it safe or not, did you do it or not, will it cause cancer or not, is it over the standard or not). Toxicological and epidemiological health data involve statistical uncertainties, and these must be addressed skillfully with the audience.

Recognize the psychology of risk aversions. Risks that are perceived to be nonvoluntary, unfair, exotic, imposed, unnatural, infrequent, dramatic, unfamiliar, and memorable tend to heighten outrage. Radon in a home is of less concern when placed there by God rather than by a chemical manufacturer (21).

Form a team. If a conflict cannot be resolved in a public meeting, assemble a team of responsible people who represent the diverse interest groups.

Most people can understand probabilistic risk, but they need assistance. Scientific jargon, such as a "statistically significant probability of 1-in-a-million risk with a chronic lifetime exposure" is not normally well perceived. The skillful use of risk comparisons (the comparison with a familiar risk) can be an effective tool in putting risks into perspective. Tables 3 through 5 show a collection of common risk comparisons, with emphasis on relative carcinogen risks based on animal studies (49–51). The classic article by Bruce Ames contains an excellent discussion of relative risk of cancer from daily exposure to common carcinogens (49).

Using risk comparisons

Great care and caution must be exercised in using risk comparisons. When a person is sincerely frightened by exposure to a chemical deemed "dimethyl doubledeath," comparison with a peanut butter sandwich may heighten outrage irreparably, even though the Aflatoxin B1 may be a much riskier carcinogen. Peter Sandman suggests that risk comparisons such as those in Tables 3 through 5 should carry a warning label: "Use of these comparisons may be dangerous to your credibility."

Nonetheless, used skillfully, comparative risks can be an effective tool for communicating risk perspectives. Consider, for example, an incinerator project in Los Angeles. The city leaders, with a critical need to provide for ultimate disposal of trash, supported unanimously the construction of a new incinerator. However, when construction was about to begin, activists became involved and killed the project on the basis of a single test, which found that stack emissions would contain trace amounts of dioxins and furans equivalent to a cancer mortality risk of 1 per 10,000,000. After being told that dioxins and furans are some of the worst carcinogens known to man, the neighbors were understandably very frightened. Showing that this cancer risk was less than that from taking 1 sleeping pill every 2000 years might have alleviated the fears, particularly if the benefit had been clearly and honestly delineated.

As shown in Table 6, we are now pursuing extremely low levels of carcinogenic risk. A typical regulatory mortality risk target is 1 in a million, which corresponds to any approximate cancer risk reduction of 0.00042%. The recent repeal of the Delaney Clause — a 1958 law banning carcinogenic pesticides in foods — required EPA to set a "reasonable certainty that no harm will result from aggregate exposure to pesticide residues in foods." For nonthreshold effects such as cancer, EPA has interpreted "reasonable certainty" as less than 1 in a million, roughly equivalent to the risk of lung cancer from 1 chest x-ray or the risk of cancer from one third of a sleeping pill. In addition to defining risk at a very low level, clearly many researchers believe that the actual risk is often substantially less (52).

The pursuit of extreme prudence, such as overregulation of environmental risk, is not without peril. University of Southern California economist Ralph Keeney has estimated that every $15 million (today's dollars) taken out of the economy through government regulations results in a loss of 1 life (53–57). Numerous other studies have effectively shown this same mortality detriment (58–61).

Scientific silence

Walter Willet of the Harvard School of Public Health has stated, "Studies have shown that people get more information about risk and hazard from the media than they do from their physicians or anyone else" (62). We believe that environmental health scientists must become more vocal and more skillful in putting environmental risks in perspective. We contend that the communication deficit is greater than the data deficit. We already know enough to be a voice of reason, but what we know is not always effectively used, often because of scientific silence.

The American Broadcasting Corporation's consumer reporter, John Stossel, speaking at a 1997 gathering of the Society of Toxicologists put it bluntly:

> One of my gripes with you (scientists) is that you let crackpots speak out. You, who know better, don't speak out. I understand. You want to keep your research funding coming in . . . you don't want to get involved in this nasty debate, you want to do your research and be left alone. But a lot of people are being led astray because you don't speak up (63).

Similarly, Norman Augustine, chair of Lockheed Martin, has stated:

> Living as we do in a "sound bite" world, scientists must learn to communicate far more effectively. . . . One must ask why, in today's technology-based society, scientists' voices are seldom heard . . . (64).

Conclusion

Good environmentalism, which we should all support, requires that we delineate more effectively risks versus benefits. Environmental health issues must be communicated more effectively to the public. At the heart of better environmental health, we believe, lies a critical need for scientists to become more active in risk communication. The proper role of science is never to impose levels of acceptable risk on the public. But, the better informed the public is, the sounder the environmental judgments it can make.

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TexasMedicine

Don't miss one word of the November issue of *Texas Medicine.*

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Physician negotiations

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Fall conference

For more information, call Larry BeSaw, editor, at (800) 880-1300, ext. 1383, or (512) 370-1383, or e-mail larry_b @ texmed.org. Also consult the TMA Web site at www.texmed.org.

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Family Practice	Oct. 14-16
Intro to PV	Dec. 3-4
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The Alliance for Medical Management Education Degree and Certificate Program—Leadership in Healthcare Organizations, Oct. 10-15 at North Dallas Renaissance Hotel. The University of Texas Southwestern Medical Center at Dallas jointly sponsored with The University of Texas at Dallas. Directors: J. Burnside, MD; J. McCracken, PhD. CME credit offered. Contact: Paul Krawietz, (214) 648-3705.

Current Issues and Practices in OB/GYN, Oct. 20-23 at Wyndham Anatole Hotel, Dallas. Sponsored by The University of Texas Southwestern Medical Center at Dallas, Department of OB/GYN. Directors: M. Bryant, MD; S. Cox, MD. CME credit offered. Contact: Jim O'Reilly, (214) 648-3794.

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Seventh Annual Update in Emergency Medicine, Nov. 19-20 in Dallas. Sponsored by The University of Texas Southwestern Medical Center at Dallas, Department of Surgery, Division of Emergency Medicine. Director: R. Charles, MD. CME credit offered. Contact: Francie Issa, (214) 648-3784.

Lymphatic Mapping and Sentinel Lymph Node Biopsy in Breast Cancer and Melanoma, Dec. 2 in Dallas. Course includes live surgery broadcast and hands-on in vivo laboratory. Sponsored by The University of Texas Southwestern Medical Center at Dallas, Department of Surgery, Division of Surgical Oncology. Directors: T. Anthony, MD; W. Erdman, MD; D. Euhus, MD; D. Matthews, MD, PhD. CME credit offered. Contact: Leah Cannon, (214) 648-3792.

Education for Physicians on End-of-Life Care, Dec. 4 in Dallas. The University of Texas Southwestern Medical Center at Dallas jointly sponsored with Zale Lipshy University Hospital. Director: C. Rubin, MD. CME credit offered. Contact: Joann Kleinneiur, (214) 648-2200.

Southwestern Center for Minimally Invasive Surgery: Comprehensive Gynecologic Laparoscopy, Dec. 10-11 in Dallas. Course includes live surgery and/or video session, hands-on videotrainer workshop and an in vivo laboratory. Sponsored by The University of Texas Southwestern Medical Center at Dallas, Department of OB/GYN. Director: R. Coleman, MD. CME credit offered. Contact: Leah Cannon, (214) 648-3792.

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TMA Planner

November 12-13, 1999
TMA House of Delegates
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Doubletree Hotel, Austin

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TMA Winter Conference
Renaissance Austin Hotel

May 25-28, 2000
TexMed 2000
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October 1999

October 7	Houston	Before You Sign on that Dotted Line
October 7	Houston	Was it Something I Said? (Medical Malpractice)
October 7	Austin	Policy and Procedure II: Employment Issues and Office Safety
October 8-10	Austin	Texas Society of Plastic Surgeons
October 9	San Antonio	New Issues Forum — Texas Society of Pathologists
October 12	Tyler	Was it Something I Said? (Medical Malpractice)
October 13	Houston	Medical Records Dos, Don'ts, and Other Intriguing Dilemmas
October 14	Dallas	Before You Sign on That Dotted Line
October 14	Lufkin	How to Establish a Peer Assistance Committee
October 14	Dallas	Policy and Procedure II: Employment Issues and Office Safety
October 20	College Station	Medical Records Dos, Don'ts, and Other Intriguing Dilemmas
October 21	Fort Worth	Policy and Procedure II: Employment Issues and Office Safety
October 26	College Station	Was it Something I Said? (Medical Malpractice)
October 27	Lubbock	Medical Records Dos, Don'ts, and Other Intriguing Dilemmas
October 27	San Antonio	Ethical and Legal Duties of the ER and On-Call Physicians
October 28	San Antonio	Before You Sign on That Dotted Line
October 30	Dallas	Beyond Survival: Techniques to Manage Stress

November 1999

November 2	Plano	Care for the Caregiver (Behavioral and Emotional Problems)
November 2	Houston	Alcohol and Other Drug Use Among Physicians
November 3	San Antonio	Medical Records Dos, Don'ts, and Other Intriguing Dilemmas
November 5-6	Dallas	Impairment Evaluation Under Texas Workers' Compensation
November 5-6	Irving	Texas Academy of Internal Medicine
November 9	Houston	Care for the Caregiver
November 10	Austin	Medical Records Dos, Don'ts, and Other Intriguing Dilemmas
November 11	Houston	Before You Sign on That Dotted Line
November 11	Houston	Policy and Procedure II: Employment Issues and Office Safety
November 17	Dallas	Medical Records Dos, Don'ts, and Other Intriguing Dilemmas
November 18	Corpus Christi	Policy and Procedure II: Employment Issues and Office Safety

Physician negotiations • Medical missions • Organ allocation

Texas Medicine

Journal of the Texas Medical Association

November 1999

TMA AND THE RIO GRANDE BORDER: A DECADE LATER

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Border health

Ten years ago, the Texas Medical Association and other groups launched the Border Health Initiative to improve the health of people on both sides of the US-Mexico border. Some improvements have been made, but there's still a long way to go. And while the legislature passed laws to help improve border conditions during its most recent session, a dengue fever outbreak in Laredo shows how complicated the border health issue can be.

By Laura Albrecht, Ken Ortolon, and Monica Maldonado

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A practice-based rural health fellowship: an innovative approach to support for rural health care. 72
By William J. Crump, MD; Robin B. Bersch, MD

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TMA has hit the ground running with the state's new physician negotiation law by developing a plan to offer representation services to physicians in their dealings with insurance plans.

By Steve Levine

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For several Texas physicians, the Middle East, the jungles of Central America, the killing fields of the Balkans, and other places a long way from home offered them the chance to rediscover the joy of practicing medicine.

By Alice Adams

"We're going to Honduras." 49

A week in Honduras reminded one Austin surgeon of why he became a doctor.

By Bruce McDonald, MD

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Organ allocation 54

It seems like a simple notion — an organ procured for donation should go to the nearest patient who needs it the most and who has been waiting the longest. But, of course, it's not that simple. While Texas waits to see how a proposed new federal rule will play out, it begins reexamining its own complicated allocation system.

By Monica Maldonado

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Eyeing a deal 60

Ophthalmologists and optometrists were eyeball to eyeball with each other over scope-of-practice issues when the Texas Legislature convened last January, and it appeared there would be a bloodletting. But the efforts of one lawmaker helped forge a compromise both sides can live with.

By Ken Ortolon

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Life-and-death decisions 64

Deciding when medical treatment is futile and it is time to let go is unquestionably the hardest decision a patient or physician has to make. A new state law makes several changes in advance directives laws and tries to eliminate some of the confusion.

By Robert L. Fine, MD, and Thomas Wm. Mayo, JD

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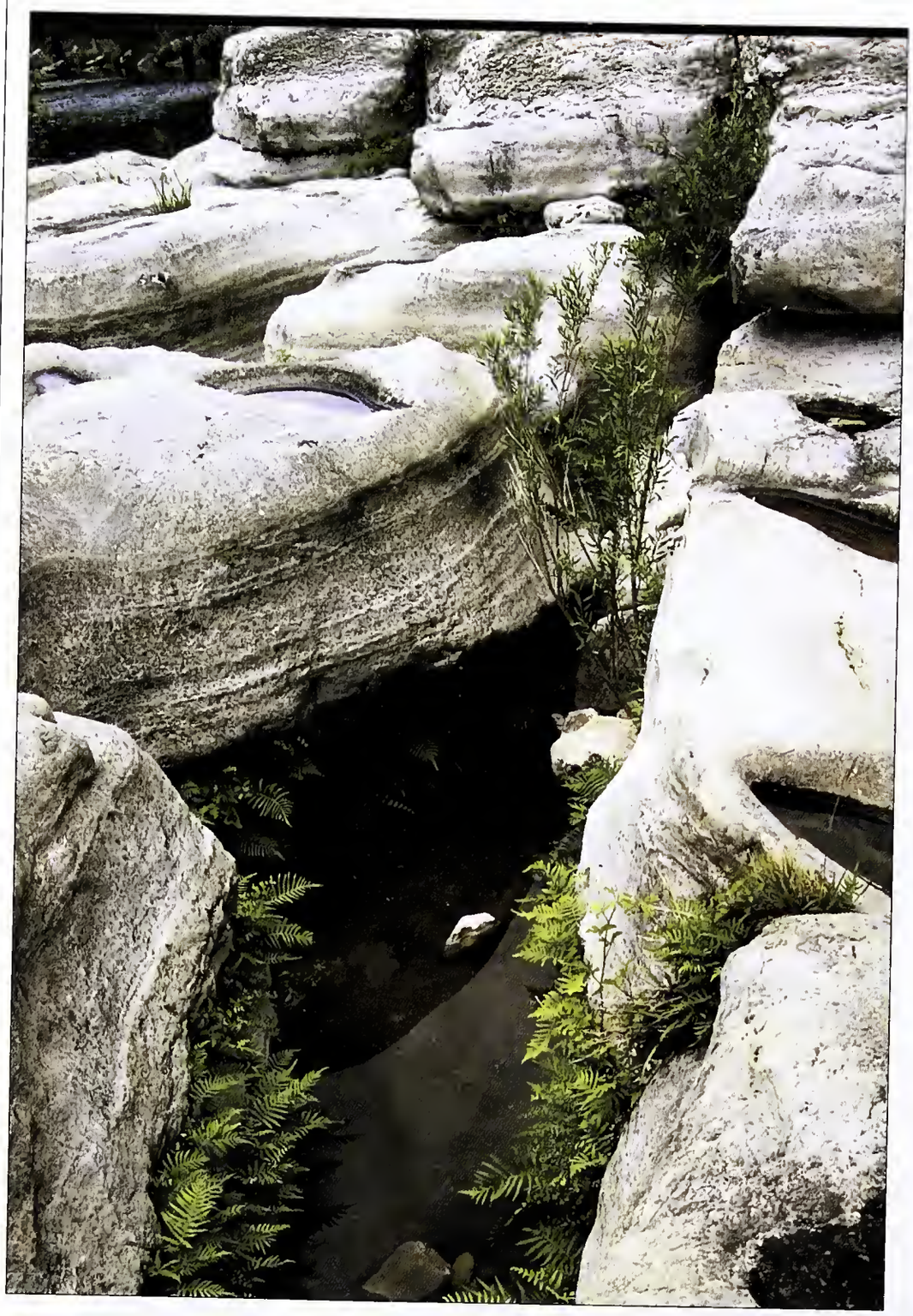

The Big Picture

Dolan Falls, by Joseph W. Goldzieher, MD, San Antonio
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Editor's Note

This issue of *Texas Medicine* may remind our older readers of a simpler time in medicine, before it was overtaken by HMOs, PPOs, CLIA, DRGs, E&M, etc. Back then, it was just a matter of patients getting sick and physicians curing them.

Read the Public Health section articles, "Mercy Missions" and "We're Going to Honduras," and you'll find inspiring stories of physicians who rediscovered what medicine is all about in such places as the Central American jungles and the Balkans. They were able to help people in need without third-party interference. There were obstacles to overcome — like having to let snakes roam refugee camps in Macedonia because they killed the rats that carried disease — but those were mild when compared with the bureaucratic nightmares physicians often face in America.

One of those physicians, Austin surgeon Bruce McDonald, MD, gives us a first-person account of the medical mission he and a team of physicians and health care professionals took to Honduras this summer. Dr McDonald says his experience there made him feel like a doctor again. Part 1 of his account appears this month, with Part 2 coming in December.

You've probably noticed a change at the back of the magazine. We've replaced "Back Talk" with the "TMA Planner," a listing of major medical meetings for the next 2 months. We hope you find it useful.

Larry BeSaw
Editor

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Commentary

Alan C. Baum, MD

William G. Gamel, MD

Is it good medicine?

By Alan C. Baum, MD, and William Gamel, MD

Most Americans, if they have heard the phrase at all, think of "litmus test" as a political term. A candidate must pass a special interest group's litmus test to win an endorsement. A president subjects potential Supreme Court nominees to a litmus test on abortion or civil rights or gun control.

As scientists, we physicians remember the real litmus test from our chemistry labs. Litmus paper turns red for an acid and blue for a base.

Either way, the term has the same connotation. It's a benchmark, an incontrovertible measurement. A compound is an acid or a base. A candidate is pro-life or pro-choice. A judge favors or opposes racial quotas.

Now, physicians have a new litmus test. The beauty of it lies in the fact that it combines both worlds. It allows us to use our clinical and scientific training to evaluate political and quasi-political issues. In fact, we can apply it in innumerable situations. And like a real litmus test, it gives us a real answer.

This new test is a phrase, a question, a four-word question. Four familiar words that follow us routinely from hospital bedside to emergency department to surgical suite to exam table. These four words are, "Is it good medicine?"

E. Ratcliffe Anderson, Jr, MD, the American Medical Association's executive vice president, started asking that question back in March during your AMA's National Leadership Development Conference. Subsequently, the question was asked in health care debates here in Texas and in Iowa, Michigan, New York, and Kansas City. The question was asked earlier this year as physicians considered national negotiating organizations and battled the Aetna-Prudential mega-merger.

Is it good medicine?

As Dr Anderson said in March, the question is a "simple diagnostic for a complicated world." Each day, we pose the question while considering treatment options for our patients. We should ask the same question when the medical marketplace starts imposing barriers between our patients and us.

Is it good medicine?

Those four words have helped to guide our deliberations over the proposed Patients' Bill of Rights, and they have become the centerpiece of our congressional lobbying efforts. The insurance industry argues that profit-driven health plans, not physicians, should make medical necessity decisions. . . . They propose to trample Texas' landmark patient protection laws. . . . They offer sham solutions to the frustrations that plague millions of Americans — and their patients.

Any good scientist knows we can find the right answer only when we ask the right question.

Is it good medicine?

Blue Cross and Blue Shield decides to stop reimbursing pathologists for supervising the safety and accuracy of our laboratories. . . . Humana institutes an arbitrary new policy to challenge every claim for high-intensity evaluation and management services. . . . Insurance companies across the state try to "slow pay" our practices to death.

Is it good medicine?

Don't let these examples fool you. This new tool is not just designed to root out bad ideas. It also validates the good. The Texas Medical Association, the TMA Alliance, and the TMA Foundation devised Project WATCH, a new community service program that gives Texas physicians the tools to combat heart disease and stroke — two of this state's top three killers. . . . Our AMA proposes a positive alternative to the

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Is it good medicine?

Any good scientist knows we can find the right answer only when we ask the right question. And we believe this powerful question can quickly bring focus to any debate.

So let us begin redefining the health care debate in Texas and our communities by redefining how we address it. Let's seek out first not the right answers but the right question. A question that can establish common ground and be an invaluable guide in designing effective new solutions to our health care problems.

Whenever health care is the issue, this should be the only real question: Is it good medicine?

Is it good medicine? You bet it is!

Dr Baum is TMA president. Dr Gamel is chair of the Texas delegation to the American Medical Association.

Hospitalist programs are acceptable if they are voluntary

By Jerry C. Daniels, MD

Hospitalists are physicians who specialize in inpatient care. Primary care physicians hand over patients to hospitalists when they are admitted to the hospital, and the patients are returned to them when they are discharged. Hospitalists are growing in number and influence within the American health care system.

The American College of Physicians-American Society of Internal Medicine (ACP-ASIM) supports this development with appropriate monitoring of its effects on patients, primary care physicians, and hospitals. Many hospitalists are trained as internists. Other internists provide much of the adult primary care. Two years ago, the National Association of Inpatient Physicians was organized to represent the nation's hospitalists; its holds its annual meeting at the same time as ACP-ASIM.

Despite its position of support with monitoring, ACP-ASIM has concerns about the hospitalist movement, specifically, whether the use of hospitalists continues to be voluntary or whether it becomes mandated and coercive.

The transfer of responsibility for inpatient care has positive features for some patients, according to some primary care physicians. These include more productive use of outpatient encounter time, shortened length of stay, enhanced patient satisfaction, and possibly even improved inpatient clinical outcomes and quality of care. Potential disadvantages, which must be weighed against the advantages, include interruption of continuity of care, miscommunication among several physicians dealing with a patient, erosion of office-based physician inpatient skills, loss of hospital staff privileges by non-hospitalists, and in the case of internal medicine, a threat to the characteristic of an internist being uniquely equipped to deal with the sickest of patients regardless of venue.

Ingrained in the training of an internist is the capability to deal with complexity and severity of illness regardless of where the care is delivered. This competence has traditionally been one of the defining characteristics of internists vis-a-vis other primary care providers. It has been a competitive advantage and a source of pride to internists, and a useful skill for patients and other primary care physicians. The blurring of this distinction for internal medicine physicians may prove to be detrimental to our competitiveness, effectiveness, and satisfaction.

Unknown issues that need study include the possibility:

- That continuity of care is critically important when patients become severely ill;
- That the costs of inpatient care may actually increase if hospitalists do not have the ability to predict individual patient response to illness;
- That there may be confusion about advance directives and that end-of-life care may be prolonged;
- That patients may be unhappy having several physicians in charge of their care as hospitalists usually rotate their hospital responsibilities in shifts; and
- That hospitalists may focus unavoidably on day-to-day problems and fail to confront long-term concerns because they are relatively isolated from whatever happens before and after hospitalization.

The key to monitoring these potentially negative effects of the hospitalist movement, when compared with the presumably positive features, resides in freedom of choice. As long as the hospitalist system is voluntary, market forces pertaining to the ultimate consumers that hospitalists serve will determine its value. If patients and other primary care physicians find that hospitalists create greater value than problems, they will prevail. Otherwise, they will be used only sparingly. It is the distortion brought about by the coercive and mandatory use of hospitalists that precludes a meaningful accounting of cost versus benefits of the hospitalist system. A mandatory approach will anger patients and create outrage among physicians.

Thus, it is the ACP-ASIM position, certainly championed by the Texas Academy of Internal Medicine, that support for the hospitalist movement is confined to a sharply delineated support for a voluntary, noncoercive hospitalist system. It is unacceptable to permit the mandatory transfer of inpatient responsibilities under any system. ★

Dr Daniels is president-elect of the Texas Academy of Internal Medicine, the Texas Chapter of the ACP-ASIM. He is a professor and associate chair of medicine in the Department of Internal Medicine at The University of Texas Medical Branch at Galveston.

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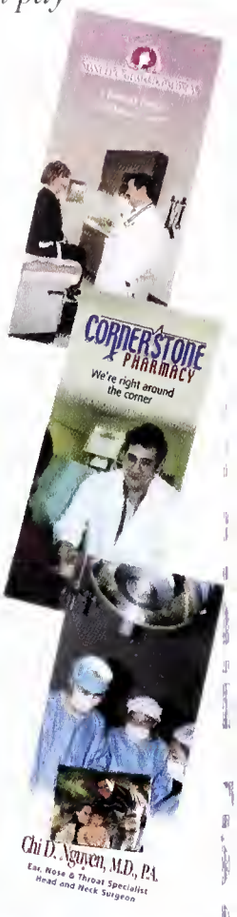

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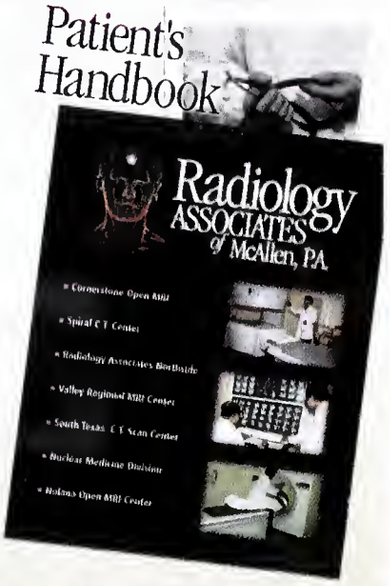

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People

Newsmakers

Three physicians at The University of Texas Southwestern Medical Center were recognized for outstanding achievements in their fields. **Paul Bergstresser, MD,** chair of dermatology, is the new secretary/treasurer of the Society for Investigative Dermatology. During his 5-year term, he will be responsible for the overall fiscal and managerial integrity of the organization. **Gregory Jackson, MD,** an associate professor of pediatrics, was named Child Advocate of the Year by the National Association of Pediatric Nurse Associates and Practitioners. Dr Jackson, clinical director of the newborn nursery at Parkland Hospital, was cited for his dedication to the promotion of the health and well-being of the children he treats. **Ishwarlal Jialal, MD,** received the Zak Award from the American Association of Clinical Chemistry for his research on lipids and lipoproteins.

John E. Bertini, MD, has been elected to the city council of West University Place near Houston. He is a urologist at CHRISTUS St Joseph Hospital in Houston.

Harris Busch, MD, PhD, a professor of pharmacology at Baylor College of Medicine, has received the J.E. Purkyne Honorary Medal for Merit in the Biological Sciences from the Academy of Sciences in the Czech Republic. He was honored for his achievements and long-term cooperation with Czech scientists. Dr Busch's primary research interest involves the structure and function of the nucleolus in cancer cells.

Paul Bergstresser, MD

Harris Busch, MD, PhD

Gregory Jackson, MD

Joseph Jankovic, MD

Frederick L. Merian, MD

Ibrahim Ramzy, MD

Douglas Curran, MD, of Athens, has been named Family Physician of the Year by the Texas Academy of Family Physicians.

The Texas Medical Foundation's physician membership has elected four new members to its Board of Trustees. They are Rio Grande City family physician **Antonio Falcon, MD;** Dallas psychiatrist and former TMA Board of Trustees Chair **Byron L. Howard, MD;** Wichita Falls pathologist **Susan M. Strate, MD;** and Lubbock cardiologist **Charles E. Wilkins, MD.** In addition, three current board members were elected officers of the board. They are Georgetown family physician **William R. Jones, DO,** vice president; Dallas ophthalmologist **John E. Eisenlohr, MD,** secretary; and Houston psychiatrist **Priscilla Ray, MD,** treasurer.

Amarillo cardiologist **Ronald Fortner, MD,** is the 1999 recipient of the Paul V. Ledbetter, MD, Physician Volunteer of the Year award from the American Heart Association, Texas Affiliate. Dr Fortner is active in the HeartCare Partnership, a joint cardiovascular disease prevention project of the Texas Medical Association and the American Heart Association. He is chief of cardiology at Baptist St Anthony's Health System in Amarillo and president and physician manager of the Amarillo Heart Group.

Please let *Texas Medicine* know about your honors and achievements. Criteria for inclusion in the Newsmakers section are TMA membership; election or appointment to an office of, or honors from, a national or state organization; or, space permitting, recognition at the local level. Items for the Newsmakers section are published at the discretion of the managing editor. Submit items for consideration, with photos if possible, to People, *Texas Medicine*, 401 W 15th St, Austin, TX 78701; fax (512) 370-1632; e-mail larry_b@texmed.org.

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People

Charles University, the oldest university in Central Europe, has awarded an honorary degree to **Joseph Jankovic, MD,** at the International Congress on Gait Disorders in Prague, Czech Republic. Dr Jankovic is a professor of neurology and director of the Parkinson's Disease Center and Movement Disorders Clinic at Baylor College of Medicine. The university awards honorary degrees to people who have made extraordinary contributions to medicine and life sciences.

Frederick L. Merian, MD, vice chair of the TMA Board of Trustees and a family physician in Victoria, has been chosen by the American Medical Association as 1 of 13 physicians to serve on the Ad Hoc Task Force on the Evaluation and Management (E&M) Documentation System. The task force will advise the AMA Board of Trustees as it works with the Health Care Financing Administration to refine, test, and evaluate the E&M documentation system before it is implemented.

Marcus Purvis, MD, of Brenham, has been elected president of the Texas Academy of Family Physicians. Dr Purvis is in private practice and is a part-time faculty advisor at the Brazos Valley Family Practice Program in Bryan.

Basil A. Pruitt, Jr, MD, clinical professor of surgery at The University of Texas Health Science Center at San Antonio, is the new president of the American Surgical Association.

His lifetime achievements and contributions to the studies of disease in cells have earned **Ibrahim Ramzy, MD,** the American Society of Cytopathology's most prestigious award. Dr Ramzy will receive the 1999 Papanicolaou Award this month at the society's annual meeting in Sacramento. The award is named for George Papanicolaou, MD, developer of the Pap test for cervical cancer. Dr Ramzy is a professor of pathology and obstetrics and director of the Cytopathology Training Program at Baylor College of Medicine.

Kaylen M. Silverberg, MD, an Austin reproductive endocrinologist, has been

People

elected secretary/treasurer of the national Society for Assisted Reproductive Technology. She also was featured in an article, "Making Miracles," in the September 1999 issue of *Parenting Magazine*.

Deaths

Dorothy Grace Finley, MD, 77; Dallas; Duke University School of Medicine, 1944; died August 15, 1999.

Simeon Hulsey, MD, 100; Fort Worth; University of Pennsylvania School of Medicine, 1925; died August 9, 1999.

William Inserni, MD, 77; Corpus Christi; University of Lausanne-Switzerland, 1958; died August 15, 1999.

Robert Lee Mathis, MD, 78; Houston; The University of Texas Medical Branch at Galveston, 1944; died September 6, 1999.

Robert George McConn, MD, 74; Houston; Baylor College of Medicine, 1948; died August 21, 1999.

Chester Lee McShan, MD, 80; Henderson; The University of Texas Medical Branch at Galveston; 1952; died August 21, 1999.

William Arthur Mitchell, MD, 84; Lufkin; University of Maryland School of Medicine, 1941; died August 18, 1999.

Robert Mitz, MD, 75; Dallas; The University of Texas Medical Branch at Galveston; 1947; died August 14, 1999.

Robert Clayton Page, MD, 66; Winnsboro; The University of Texas Southwestern Medical School at Dallas, 1962; died August 6, 1999.

Donald Lowell Paulson, MD, 86; Dallas; University of Minnesota Medical School-Minneapolis, 1936; died August 31, 1999.

Stephen Alderman Powers, MD, 82; Wichita Falls; Baylor College of Medicine-Dallas, 1941; died August 15, 1999.

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Texas Medicine Rounds

TMA-Humana deal, physician negotiations highlight fall conference activities

An agreement with a major insurance company that will benefit physicians and an effort to help Texas Medical Association members negotiate better contracts with health plans were announced by TMA President Alan C. Baum, MD, of Houston, during the TMA Fall Conference, "Turning Points in Medicine," in Austin on September 18.

During his remarks opening the conference, Dr Baum said talks between TMA and Humana resulted in Humana agreeing to replace its audits of all claims using Level 4 and 5 evaluation and management codes with focused medical review. Humana also agreed to create a workgroup of medical directors and practicing physicians to enhance the review process and improve physicians' working relationship with Humana.

"We got their attention," Dr Baum said. "We told them it didn't make

Jim Lincoln

Organized medicine must stay together and work to maintain a health care system that is in the best interests of the patients, American Medical Association President Thomas R. Reardon, MD, said at the TMA Fall Conference. "Our patients need us to be strong, united, visionary advocates on their behalf so they can continue to receive necessary and appropriate care."

Physicians must be prepared if the unthinkable happens and terrorists launch a chemical or biological attack against the United States, Dennis Perrotta, PhD, chief of the Bureau of Epidemiology at the Texas Department of Health, said during a program on bioterrorism at the TMA Fall Conference.

sense for physicians or for Humana. It was a waste of time, money, and energy. We suggested instead that Humana use focused medical review. Only claims from physicians whose coding consistently falls outside the normal range of others in their specialty should be audited. And they listened."

Dr Baum also announced that the TMA Board of Trustees had voted to take the first steps toward creating a TMA physician negotiation unit to represent groups of Texas doctors in contract talks with health plans. (See "TMA at the Table," p 28–32.) That action followed passage of Senate Bill 1468, known as the Physician Negotiation Bill, in the last session of the Texas Legislature.

In a related matter, American Medical Association President Thomas R. Reardon, MD, told conference attendees that unprecedented physician frustration led AMA to create a collective negotiating organization for employed physicians last summer. (See "AMA Preparing to Act, PRN," p 32.)

In his remarks, Dr Baum said Texas physicians have "encountered enough turning points lately to keep us all spinning, but we don't have to be blown off course. That's a challenge for each of us individually, and it's a challenge for TMA."

TMA has the talent and the resources, he said. "We have the solid relationships with our county societies, with the specialty organizations, and with AMA. This association is going about what it ought to be going about. We're going to make good things happen for Texas doctors who are dealing with these turning points."

One of those good things TMA will make happen, he said, is securing congressional passage of a Patients' Bill of Rights that will truly benefit patients. "We're going to win this one because we're right. If not today, then soon," he declared. "TMA is organizing grassroots physicians to encourage our Texas representatives to protect the tremendous patients' rights victories we've won here in Texas."

Dr Baum said TMA also will work for physicians and their patients on issues such as Medicaid managed care, disease management programs that threaten physician autonomy, pharmacy benefits managers and formulary manipulations, mergers, mandated benefits, and the constant downward pressure on reimbursement.

Lieutenant Governor Rick Perry and House Speaker Pete Laney have asked legislative committees to study these issues between now and the next session in 2001. "Our study groups and specialty coalitions will develop the best policy options for Texas physicians and our patients," Dr Baum said. "We'll deliver the information. We'll deliver the science. We'll be the authority at that table. And we know our senators and representatives will listen to TMA because they've learned to trust what we have to say."

Fall conference events concluded with a program on the physician's role in biological and chemical terrorism. It was produced by TMA and the Texas Public Health Association and funded by AMA and the American Public Health Association.

Kenneth Kizer, MD, MPH, former undersecretary of health for the US Department of Veterans Affairs, said physicians "are the frontline responders to bioterrorism. How one determines an organized response should be predicated on that, and that basic fact is not understood by a whole lot of people who still think they're going to go out in a fire engine or with red lights and sirens and deal with something they completely don't understand."

The United States faces a growing population, increasing technology, and outdated disaster response plans at hospitals. These all spell trouble for physicians who are not prepared for the threat of chemical or biological attack, said Dennis Perrotta, PhD, chief of the Bureau of Epidemiology at the Texas Department of Health. Unlike chemical attacks, the release of biological agents may not be readily apparent.

"The first clue will be people showing up in your offices with flulike illnesses, and you will say that they have the flu because they're horses and you're not looking for zebras yet," he said. Once the zebras have been identified, Dr Perrotta said, "The response to this kind of problem is a local function — it has to be a local law enforcement and a local health combination." ★

Jim Lincoln

Texas legislators received the "Texas Medicine's Best" awards at the fall conference for their passage of legislation benefiting physicians and their patients during the past session of the Texas Legislature. From left are Rep Garnet Coleman (D-Houston), Rep John Smithee (R-Amarillo), Rep Glenn Lewis (D-Fort Worth), Rep Patricia Gray (D-Galveston), Sen Jane Nelson (R-Flower Mound), Sen Chris Harris (R-Arlington), Rep Kyle Janek (R-Houston), and Rep Brian McCall, (R-Plano). Also receiving the awards but not pictured were Lt Gov Rick Perry, Rep Craig Eiland (D-Galveston), Rep Rob Junell (D-San Angelo), and Rep Barry Telford (D-DeKalb). Because of their efforts, critical public health causes were advanced by the legislature, said Robert W. Sloane, Jr, MD, Fort Worth, chair of the TMA Council on Legislation.

Jim Lincoln

Lloyd Woodward, MD, of Robert Lee, shows Michael Fitzpatrick, MD, a professor at The University of Texas Southwestern Medical Center at Dallas, how to find information about cancer-related legislation on the World Wide Web during the Internet Health Road Show.

Surf's up! The main ballroom of the Renaissance Austin Hotel was packed with doctors and computers for the Internet Health Road Show. More than 250 physicians learned how the Internet is revolutionizing health care from computer-savvy fellow physicians and computer industry experts.

Internet: get on or get out, physicians learn at road show

Remember when Woolworth's was the dominant force in retailing? Everybody shopped there. Woolworth officials were so confident in their market supremacy that they paid little attention to that Walton fellow in Arkansas. Have you seen a Woolworth's lately?

If doctors don't want to end up on the scrap heap like Woolworth's, they'd better start incorporating the Internet into their practices, Richard F. Corlin, MD, speaker of the American Medical Association House of Delegates, told more than 250 physicians who took part in the Internet Health Road Show September 17 in Austin.

Sponsored by AMA and Intel Corporation and held in conjunction with the Texas Medical Association Fall Conference, the event gave physicians a first-hand look at how the Internet is changing the practice of medicine, especially the relationship between patients and physicians. Dr Corlin and other speakers discussed the Internet's impact on the patient-physician relationship, identified major physician and consumer Internet health sites, and familiarized attendees with Internet tools they can use in clinical practice, office management, and patient education.

Like Woolworth's, Dr Corlin said, physicians are confident they are the dominant players in health care. But that could change.

Patients are surfing the Web to get information, order prescription drugs, purchase health insurance and medical supplies, discuss their illnesses or conditions with physicians, and, in some cases, actually obtain diagnoses.

Patients often are going to their doctors' offices with questions about drugs or treatments they found on Internet health sites. Physicians can turn this development to their advantage and help their patients find sources of accurate information on the Internet. Patients want information from physicians to validate or refute what they find on the Internet, Dr Corlin said.

Surveys show the overwhelming majority of patients prefer to receive information from their physicians, added Robert McKinstry, MD, PhD, assistant professor of radiology at Washington University School of Medicine.

"Patients are seeking someone to talk to and a sense of community. Physicians can help them find that online," he said.

"The good news is there are 50,000 health-related Internet sites," said Steven McGeady, director of the Internet Health Initiative for Intel. "The bad news is there are 50,000 health-related Internet sites. The only way to determine what the future of health care on the Internet looks like is to become involved in it."

An increasing number of physicians are using the Internet to get help and information, Dr Corlin said. "It will result in better educated patients. It will result in patients having far more of a feeling that they have participated in the development of their treatment plan . . . and I believe that we will have increased compliance on the part of the patients."

Speakers at the road show advised physicians to keep up with the information and services available to their patients on the Internet, to develop Web sites for their practices, to make their e-mail addresses available to patients, and to incorporate their patients' e-mail addresses into their medical charts. ★

Jim Lincoln

Physicians must be accountable for their actions to maintain quality of care, John Eisenberg, MD, administrator of the federal Agency for Health Care and Policy Research (AHCPR), said during his presentation at the TMA Fall Conference. Among the steps physicians can take to be accountable, he said, is providing high-quality care based on high-quality research evidence. To help provide such care, an AHCPR Internet site at www.guidelines.gov offers a compendium of evidence-based treatment guidelines developed by AHCPR, AMA, and the American Association of Health Plans.

TMA, TMAA members WATCH over Texans' hearts and brains

Clyde W. Yancy, Jr, MD, always includes a slide in his presentations that says, "The best way to treat heart failure is to not get it." This motto made him the perfect speaker to introduce Texas Medical Association Fall Conference attendees to Project WATCH, a new heart disease and stroke prevention education program by TMA, TMA Alliance, and TMA Foundation.

Dr Yancy, an associate professor of medicine in the Department of Internal Medicine-Division of Cardiology at The University of Texas Southwestern Medical Center at Dallas, emphasized the simplicity of the Project WATCH prescription. "We cardiologists have really tried to make this unnecessarily complex," he said. "It's not that complicated. You help your patients lose weight. You help them increase their activity. Encourage them to stop smoking, encourage them to follow heart-healthy diets, and encourage them to get their blood pressure checked."

The 2-year project fights the No. 1 and No. 3 killers in the state and the country — heart disease and stroke — by educating physicians and their patients about the five leading preventable risk factors for heart disease and stroke: Weight, Activity, Tobacco, Cholesterol, and High blood pressure.

Fall conference attendees also learned about Project WATCH through a booth featuring stations for each of the risk factors. TMA-Medical Student Section members performed cholesterol screenings and blood pressure checks on booth visitors, as well as on TMA President Alan C. Baum, MD, and TMA Alliance President Pam Hendricks, of Temple.

During his presentation at the TMA Alliance Fall Conference, Temple cardiologist and TMA President-Elect J. James Rohack, MD, laid out the initial steps for the Project WATCH implementation plan. "Our first act is to get out there and find out from the physicians, our spouses, and our families if we are at risk," he said. "Do we have some of these risk factors that we're not paying attention to so that we can take care of others?"

Following the physician education phase of Project WATCH, TMA, the TMA Alliance, and the TMA Foundation will launch the public phase of the program with patient brochures, a Project WATCH video, and a press conference at TMA's Winter Conference on February 26, 2000, in Austin. ★

Jim Lincoln

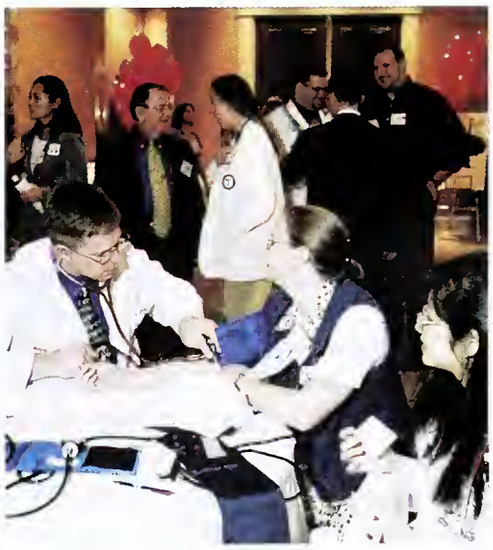
Clyde W Yancy, Jr, MD, introduces TMA Fall Conference attendees to the five preventable risk factors for which Project WATCH was named: Weight, Activity, Tobacco, Cholesterol, and High blood pressure. "The reason I am giving this message, apart from my own professional affiliations, is because as a practitioner who deals with end-stage heart disease, I see the consequences of these unchecked, uncontrolled risk factors and these morbid cardiovascular facts," Dr Yancy said. "It galvanizes me to get a message out to the physician community that these issues are vitally important."

Jim Lincoln

Texas Medical Association-Medical Student Section (TMA-MSS) Chair Brad Butler, a third-year medical student at Texas A&M University Health Science Center in Temple, far left, and TMA-MSS Vice Chair Angela Siler-Fisher, a third-year medical student at Texas Tech University Health Sciences Center in Lubbock, second from right, perform cholesterol tests on TMA President Alan C. Baum, MD, far right, and TMA Alliance President Pam Hendricks, in front of TMA Fall Conference attendees to help launch Project WATCH.

Jim Lincoln

From left to right, TMA President Alan C. Baum, MD, TMA Alliance President Pam Hendricks, TMA Alliance President-Elect Irene Skor, and TMA President-Elect J. James Rohack, MD, celebrate the physician kickoff of Project WATCH, a 2-year heart disease and stroke prevention education program by TMA, the TMA Alliance, and the TMA Foundation.


Jim Lincoln

Members of TMA's Medical Student Section perform blood pressure checks on TMA Fall Conference attendees who visited the Project WATCH booth.

WEB SITES OF INTEREST TO TEXAS PHYSICIANS BY JENNIFER OWNBY

MedBytes

The Texas-Mexico border holds a unique mixture of cultures in an area between two countries. It has its own unique health problems, too. To find out more, visit some of the sites featured this month.

Texas-Mexico border health survey

The main purpose of this border health survey, at srph.tamu.edu/html/survey.html, is to assess general sanitation, selected health conditions, and potential sources of exposure to environmental contaminants along the border in urban and rural Mexico. Overall, the survey compares environmental health conditions in the principal population areas of the border (ie, Brownsville, McAllen, Laredo, Eagle Pass, Del Rio, El Paso, and the *colonias*) and focuses on the health status of children. The site offers demographics and disease rates for the population.

Project Concern International

Project Concern International is a nonprofit corporation that works with volunteers and communities to provide health services around the world. The organization's Web site, www.serve.com/PCI, provides information about public health projects funded by the company. To view details about the projects, click on "Programs," then on "Mexico." Additionally, you can leave your e-mail address to receive the organization's online newsletter, ***CONCERNews***. Project Concern's programs include well-baby clinic setup, an AIDS prevention education program, women's and reproductive health programs, and community health care worker training.

Drug abuse prevention along the border

The National Center for the Application of Prevention Technologies aims to prevent substance abuse in the border area. The site, www.bordercapt.org, provides links to articles and statistics on substance abuse among border residents, and also lists conferences and events that focus on substance abuse prevention. The organization serves the US-Mexico border region in California, Arizona, New Mexico, and Texas.

TMA's new Web site

The TMA Web site is getting a face-lift. Be one of the first to view the new site in December at www.texmed.org. In addition to a new look, TMA's site will include features of interest to physicians, such as personalized home pages. Each time you log on to the TMA site, you'll see your personal home page, complete with content based on your interests. The home page will be based on a profile you've created that allows selection of user name, password, and area of specialty, as well as favorite links to outside Web sites. The site also will display catalogs of news from other medical sites. And, you'll be notified of events of interest in your area.

MedBytes is a quick look at new, or newly discovered, Web sites of interest to Texas physicians. The column also highlights features of the TMA Web site at www.texmed.org. If you know of some cool medical sites or have questions about how to use the TMA Web site, e-mail jennifer_o@texmed.org. Publication of information about Web sites in this column is not to be considered an endorsement or approval by the Texas Medical Association of the sites or sponsors, or of any products or services involved.

TMA Foundation awards grants for health initiatives

Almost $200,000 in grants to help fight cardiovascular disease, improve stroke and health education for Texas' growing Spanish-speaking population, and to help fund public health and science programs developed by county medical societies and TMA Alliance chapters were awarded by the Texas Medical Association Foundation (TMAF) Board of Trustees on September 17.

The board approved support for the first phase of the Project WATCH heart disease and stroke prevention effort. A related grant was approved for TMA's Stroke Project, an on-the-road education seminar aimed at reducing disability and death from stroke. The foundation's support will fund 42 speaker slide kits on treatments available to reverse the effects of stroke. The kits will be used by the program's speakers' bureau.

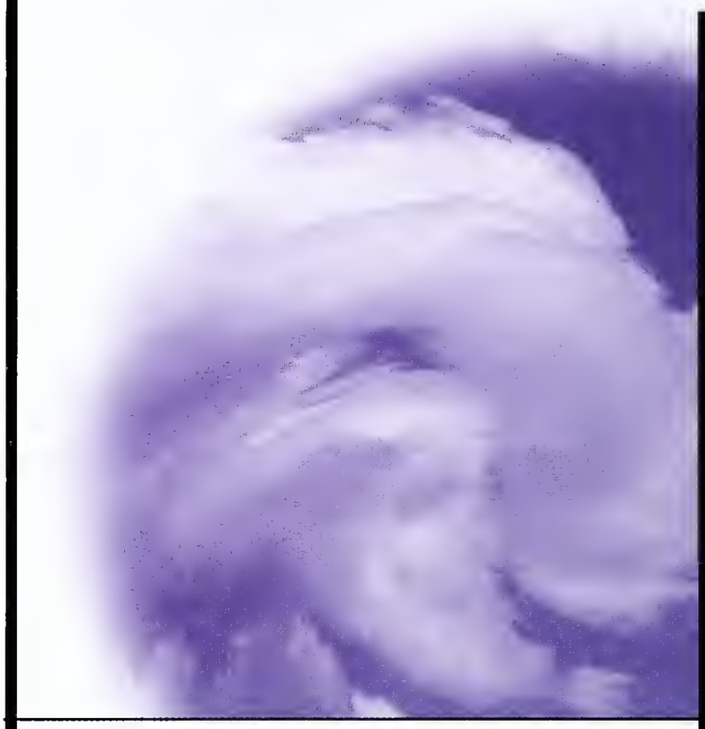
Foundation trustees also approved grants for Health*Line* Texas Spanish radio news feeds, a service of the TMA Media and Public Relations Department that provides prepared radio stories in Spanish on health topics of particular relevance and interest to Texas' Spanish-speaking residents.

For the seventh year, the Foundation provided support for TMA's Hard Hats for Little Heads, a life- and injury-saving program that gives Texas children free bicycle helmets and educational flyers on proper helmet use and bike safety.

Also approved was a grant to help expand TMA's Internet and other interactive technologies. Goals of this 3-year project include providing more online, interactive educational experiences for physicians, expanding information and resources available to both physicians and the public, and establishing a virtual medical library for physicians.

TMAF Community Grant program awards approved by the foundation board were:

- 1999 Immunization Day, sponsored by the Galveston County Medical Society, the Galveston Partnership for Better Living, the Galveston County Health District, and The University of Texas Medical Branch at Galveston. The project is designed to raise the immunization rate of Galveston County's preschoolers.
- Amarillo Live & Then Give, sponsored by the Potter-Randall County Medical Society and Alliance. The project, modeled after the TMA/TMAA statewide Live & Then Give program, consists of house calls, donor material distributed through physicians' offices, public service announcements, and a concert by country singer Deana Carter.
- The Billboard Project, sponsored by the Smith County Medical Society Alliance. This project will erect billboards on family violence and organ donation.
- El Paso Physician Television Program, sponsored by the El Paso County Medical Society. This involves local physicians who plan, promote, and appear live on television to answer questions from the public about prepublicized health issues.
- Faces of Violence Conference, sponsored by the Tarrant County Medical Society and Women's Haven of Tarrant County. This conference is expected to draw 500 people to learn more about family violence and its effects on the community.
- Garden for the Blind, sponsored by the Ector County Medical Alliance and the Ellen Noel Art Museum. A sculpture garden as a science education activity for the visually impaired is the focus of this project. It also educates the sighted on blindness.
- Hard Hats for Little Heads, sponsored by the McLennan County Medical Society. This injury prevention program has become a source of helmets and bike safety information for the community and for involvement by local physicians.
- Hopkins County Community Action Network, sponsored by the Hopkins-Franklin County Medical Society and Hopkins County Memorial Hospital. The project will compile and distribute a health and social service resource directory to physicians, other health and social service professionals, educators, ministers, law enforcement personnel, attorneys, judges, and concerned citizens.
- School Field Trip Program, sponsored by the Harris County Medical Society and the Museum of Health and Medical Science. Three school districts send children in the fifth through eighth grades to the museum for hands-on, quality health education.
- Prescriptions for Life, sponsored by the San Patricio-Aransas-Refugio County Medical Society and Aransas County Counseling and Educational Support Services. This project consists of meetings and field trips for youngsters aged 12–17 years to raise their awareness about responsible behavior, increase their self-esteem, and teach them how to handle family relationships, including drug and alcohol abuse in the home. It also will help the youth to set priorities and develop healthy habits.
- Prescriptions for the Next Step, sponsored by Bell County Medical Alliance and Families in Crisis, Inc. It will educate physicians about the importance of screening patients for family violence issues, and assist them in meeting reporting and referral requirements. Alliance members will distribute project material, promote the project, and train as project educators.
- Prescription for the Next Step, sponsored by the Taylor-Jones-Haskell County Medical Society and Noah Project, Inc. This collaborative educational effort between physicians and the community focuses on ways to assist victims of domestic violence and to expand these efforts into West Central Texas.
- The Women's Shelter/Safe Mom Healthy Families, sponsored by the Arlington Medical Society Alliance. This health-related intervention program includes alliance members staffing the emergency shelter nurse's station and supplying it with equipment, over-the-counter medications, and other necessities.
- Bone Marrow Donor Program, sponsored by the Travis County Medical Alliance. The project seeks to increase the number of persons on the donor registry of the Blood and Tissue Center of Central Texas. ★



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House of Delegates meets in Austin this month

An update on legislation passed this year by the Texas Legislature and bills still pending in Congress will be presented to the Texas Medical Association House of Delegates when it holds its interim session November 12–13 at the Doubletree Hotel in Austin.

Robert W. Sloane, Jr, MD, of Fort Worth, chair of the TMA Council on Legislation, and Kim Ross, TMA vice president for public policy, will make the presentation, which also will cover studies on various health care issues under way between now and the next session of the Texas Legislature in January 2001.

Besides legislation, the House of Delegates agenda includes socioeconomic, public health, scientific affairs, medical education, and association organizational issues.

Also scheduled are meetings of the councils on Annual Session, Health Service Organizations, Legislation, Past Presidents, Scientific Affairs, and Socioeconomics; and committees on Cardiovascular Diseases, Emergency Medical Services and Trauma, Health Initiatives (Project WATCH), Infectious Diseases, Interspecialty Society, Patient-Physician Advocacy, Rehabilitation, Rural Health, and TMA Physician Services.

Other meetings during interim session include the Young Physician Section Governing Council, and the International Medical Graduate, Organized Medical Staff, and Resident and Fellow sections; and caucuses of the Bexar, Dallas, Harris, and Travis county medical societies, the 13th District, Districts 1–4, Small Districts, Family Practice, and Medical Student Section.

For more information, contact Pam Hale at (800) 880-1300, ext 1304, or (512) 370-1304; or e-mail pam_h@texmed.org. ★

WHAT YOUR PATIENTS ARE READING

Dateline: Health

By Laura Albrecht

The following is a collection of current consumer magazine articles that feature health and medical information that your patients may read and ask you about. Send your suggestions and comments to Laura Albrecht, *Texas Medicine*, 401 W 15th St, Austin, TX 78701; or e-mail laura_a@texmed.org.

"POKE ME, KNEAD ME, HEAL ME." Searching beyond ice, aspirin, and physicians leads to care from acupuncturists, chiropractors, and massage therapists. *Women Outside*, Fall 1999

"SHAPED BY LIFE IN THE WOMB." Research claims that certain illnesses (obesity, diabetes, breast cancer, and cardiovascular disease) are determined in the womb. *Newsweek*, 9/27/99

"THE TEXAS TWENTY." Austin cyclist and cancer survivor Lance Armstrong and Fort Worth physician Edward W. Guinn, MD, who cares for one of the toughest communities in the state, are profiled. *Texas Monthly*, 9/99

"FUELING UP FOR THE HUNT." Hunters will enjoy "less fatigue, more endurance, and more kills" if they eat the right foods before and during the hunting season. *Field & Stream*, 10/99

"THINGS THAT GO BUMP IN YOUR BODY." Physicians explain when patients should and should not worry about breast lumps, ear bumps, and moles. *Glamour*, 10/99

"SUNDANCE KID." Jamie Redford (yes, the son of Robert) has undergone two liver transplants and is determined to spread the word about the importance of organ donation. *People*, 9/27/99

"SPIN CONTROL." You are dizzy, but why? Hormones? Hunger? Or something really scary? Doctors from Johns Hopkins University School of Medicine are interviewed about symptoms and solutions to dizziness. *Good Housekeeping*, 10/99

"IN IT TOGETHER." Couples discuss the medical (and emotional) uncertainties of prostate cancer. *Good Housekeeping*, 10/99

"A TALE OF TWO SEXES." The gender gap in medicine — how does it impact the treatment of women? *Shape*, 10/99

SUMMARIES OF RECENT HEALTH CARE FINDINGS

In Case You Missed It

Prenatal supplements of 1,000 mg per day of vitamin C and 400 IU per day of vitamin E can help prevent the onset of preeclampsia in women at high risk, investigators in London have determined following a study of 283 women. *Lancet*, 9/4/99

Kicking the cocaine habit may be especially tough because it triggers a buildup of a protein that persists in the brain and stimulates genes that intensify the craving for the drug, Yale School of Medicine researchers report. The protein, Delta-FosB, isn't produced in the brain until addicts have used cocaine several times or even for several years. *Nature*, 9/16/99

Healthy women who take up to 6 aspirin tablets a week have a lower risk of ischemic stroke, but those who take 15 or more tablets weekly double their risk of a subarachnoid hemorrhage, say researchers at Harvard Medical School and Brigham and Women's Hospital in Boston. *Stroke*, 9/99

Elevated concentration of plasma homocysteine appears to be a risk marker for cardiovascular disease, according to researchers at Hadassah University Hospital in Jerusalem and Tufts University in Boston. *Annals of Internal Medicine*, 9/7/99

A 12-week study shows creatine causes changes in muscle fiber and makes athletes stronger and able to lift more weight. Creatine helps the body replenish adenosine triphosphate. *Medicine and Science in Sports and Exercise*, 8/99

Scientists in Norway have linked dyslexia to a gene, DYX3, found on chromosome 2 by studying 36 members of a Norwegian family with a history of mild to moderate dyslexia. *Journal of Medical Genetics*, 9/99

Blueberries may help improve memory and balance, at least in rats. A study in which elderly rats were given the human equivalent of a half cup of blueberries a day resulted in better short-term memory, balance, and coordination. *Journal of Neuroscience*, 9/99

The health benefits of drinking red wine may be caused by purple grape juice's effect on flow-mediated vasodilation and inhibition of LDL cholesterol oxidation, say Wisconsin University researchers. *Circulation*, 9/7/99

Remember the Alamo, but remember TexMed, too

You can visit the Alamo, Sea World, or the scenic River Walk, and make your voice heard on important issues at TexMed 2000 in San Antonio during the Memorial Day weekend.

TMA's annual meeting will be held at the Henry B. Gonzalez Convention Center and Marriott Rivercenter Hotel May 25–28, 2000.

More than 200 hours of Category 1 continuing medical education will be available. In addition, you'll receive discounts on hotel rooms and tickets to theme parks.

The Marriott Rivercenter will be the host hotel with the Marriott Riverwalk, the Hilton Palacio Del Rio, and the Hilton Plaza also providing housing. All room reservations must be made through the San Antonio Convention and Visitors Bureau's Housing Bureau. Reservations will not be available until January 2000. Watch for information on room rates and reservation procedures in future issues of *Texas Medicine*.

Updated information will be provided on the TexMed 2000 Web site at virtual.texmed.org. Check out San Antonio's Web site at www.sanantoniocvb.com, and plan to make this Memorial Day weekend one to remember. ★

AMA selects new editor for *JAMA*

Catherine D. DeAngelis, MD, MPH, is the new editor of *The Journal of the American Medical Association* (*JAMA*) and editor-in-chief of AMA's Division of Scientific Information and Multimedia. She was the unanimous choice of a search committee formed after the departure of longtime *JAMA* Editor George Lundberg, MD.

Dr DeAngelis is *JAMA*'s 15th editor and its first woman editor. She has been editor-in-chief for the *Archives of Pediatrics & Adolescent Medicine* since 1963. She also is vice dean for academic affairs and faculty and professor of pediatrics at Johns Hopkins University School of Medicine. ★

Texas Tech jockeys for border medical school

Texas Tech University's plans — announced in August — to make the school's Health Sciences Center at El Paso a 4-year medical school are preliminary, medical school dean Joel Kupersmith, MD, told the TMA Council on Medical Education during the TMA Fall Conference in September.

Pending approval of all interested parties, including the Texas Legislature and the Texas Higher Education Coordinating Board, transforming the school would be a 10-year process, Dr Kupersmith said.

While The University of Texas Health Science Center at San Antonio and Texas A&M are both establishing extension campuses in the border region, Texas Tech is the first to propose a full 4-year medical school. The El Paso campus currently educates about 100 third- and fourth-year medical students and trains about 170 residents. The plan would add about 100 medical students each year and maintain the same number of residents.

Though TMA has taken a "no more students" stance on Texas physician workforce issues, Texas Tech reports that strong local and political support exists for a 4-year medical school in El Paso.

Dr Kupersmith told the council he believes the total budget for the project would be about $150 million and added that the Texas Tech Board of Regents has yet to act on the plan. ★

UT Southwestern gets big bucks for research

The University of Texas Southwestern Medical Center in Dallas has received a multimillion-dollar transfusion of the lifeblood of research — money. School officials announced they have received three grants totaling almost $26 million for cardiovascular disease, inflammatory bowel disease, and general research projects.

The largest grant — $24 million — came from the Donald W. Reynolds Foundation, named for the late newspaper, television, and cable television mogul, for cardiovascular clinical research. It is the largest peer-reviewed grant ever made to UT Southwestern and will establish the Donald W. Reynolds Cardiovascular Clinical Research Center. The grant will advance research into the prevention and treatment of heart disease caused by atherosclerosis.

UT Southwestern scientists will use molecular and clinical research techniques to examine multiethnic patients, develop new biotechnology, and establish a training program for scientists-physicians.

The second gift of $1 million will establish the Pollock Family Center for Research in Inflammatory Bowel Disease. The Pollock Foundation, established by Dallas philanthropists Hortense and Lawrence Pollock, is a longtime supporter of UT Southwestern.

A $785,000 bequest from the late petroleum engineer Robert H. McLemore will be used for general clinical and research efforts. ★

Diabetics encouraged to get flu vaccinations

With winter bearing down, the Centers for Disease Control and Prevention (CDC) and state health departments across the nation are launching a campaign to encourage diabetic patients to get vaccinations against the flu and pneumonia.

Radio, television, and print public service announcements will encourage diabetic patients to contact their physicians or local health departments for dates, times, and locations where vaccinations are given.

The Texas Diabetes Council estimates that only about half the diabetic patients received flu shots last year, and only about 30% received pneumonia vaccinations. Diabetic patients are six times more likely to be hospitalized with flu complications, the CDC says. ★

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Project WATCH, a new cardiovascular disease and stroke prevention education program, aims to knock the No. 1 and No. 3 killers of Texans off the charts.

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TexasMedical Association
TEXAS MEDICAL ASSOCIATION ALLIANCE
TMA FOUNDATION

TMA seeks nominees for science teaching awards

TMA is looking for a few Mr or Ms Wizards across Texas to honor for their ability to teach science. Nominations are being accepted for the Excellence in Science Teaching Awards, established by TMA in 1990 to recognize Texas teachers who inspire future scientists and physicians and who promote scientific literacy and education. The deadline for nominations is January 31, 2000.

Texas elementary, junior high, and high school science teachers are eligible. For each level, a first place award of $1,000 and a merit award of $500 are given. In addition, a $5,000 grant funded by Shell Oil Company Foundation will be awarded to each first place winner's school.

First place winners will be recognized during the opening session of the TMA House of Delegates at TexMed 2000 in San Antonio.

Winners are selected for their innovative approaches to teaching science, evidence of continued professional growth, and their reputation among their peers. County medical societies, TMA Alliance members, school principals, superintendents, and PTA/PTO presidents may nominate an eligible teacher for the award.

Nomination forms are available on the TMA Web site at www.texmed.org (click on "Health & Science" and then "CME Offerings, Awards & Scholarships") and available by mail or fax.

For more information, contact Jill Aslakson at (800) 880-1300, ext 1412, or (512) 370-1412; or e-mail jill_a@texmed.org. ★

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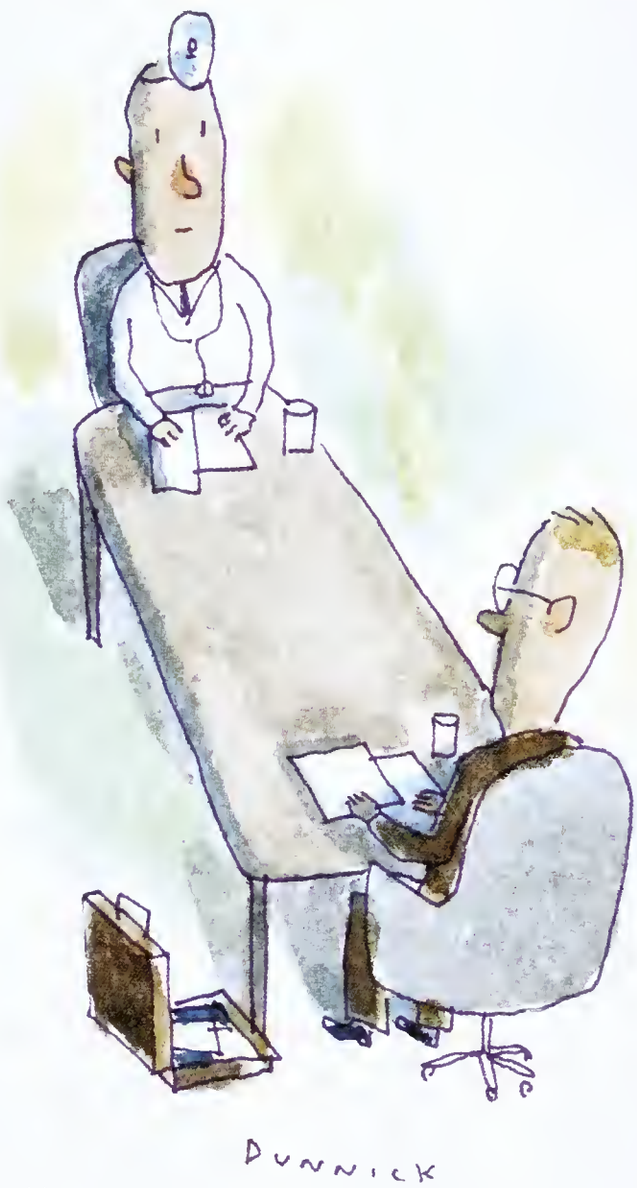
TMA at the table

Association plans new services to make new negotiating law workable



Regan Dunnick

Taking a running start at a moving — and often baffling — target, Texas Medical Association leaders are trying to shape the structure of the state's new physician negotiation law even as they prepare to help Texas physicians take advantage of it.

When the 76th Texas Legislature convened in January, no one expected to even see a bill that would provide antitrust enforcement protection for independent physicians who want to jointly negotiate contracts with health plans. But an intense grassroots lobbying campaign and strong support from some of Texas medicine's most powerful statehouse allies helped physicians triumph in a titanic debate against business and insurance interests. ➤➤

By Steve Levine, TMA communication director

Governor George W. Bush's signature turned the bill into law; now it's up to Atty Gen John Cornyn to turn the physicians' dream into a workable reality. All negotiations must be approved and supervised by the attorney general's office to qualify for the new law's protections.

"The attorney general's office is fully prepared to work with physicians on this new law," said Ted Delisi, spokesperson for General Cornyn. "We expect additional rulemaking to be completed by the end of the year."

What the law allows

If followed correctly, the law provides protection under the "state action doctrine" from an antitrust violation when physicians negotiate and discuss 19 types of contract issues with the health plans. Those types of issues include:

- Patient referral procedures;
- Utilization review and quality assurance procedures;
- Formulation of reimbursement methodology;
- Programs to improve the cost-effective delivery of preventive services and to improve health care delivery to women;
- Clinical criteria relating to disease management programs and clinical guidelines;
- Programs to enhance patient education and treatment compliance;
- Methods to detect and prevent health care fraud and abuse;
- Physician selection and termination criteria; and
- Administrative issues, such as timing of payment.

Negotiations or communications related to reimbursement rates are allowed only when a health plan has substantial market power and the plan's fee schedule threatens to — or does — jeopardize patient access to care. The law also permits negotiations only when the group of physicians comprises no more than 10% of the physicians in a health plan's geographic service area. The attorney general will define "substantial market power" and has authority to modify the 10% rule on a case-by-case basis.

Both the new law and the Code of Medical Ethics prohibit physicians from using strikes, boycotts, or other work stoppages that could interfere with patient care. Negotiations under the new law are voluntary and nonbinding for physicians and for health plans. Plans retain the right to contract with or offer different terms to individual physicians.

TMA at the bargaining table

Negotiating physicians may designate a third party to represent them during the talks, and that's where TMA comes back into the picture. The association's Board of Trustees has approved the development of a strategic plan under which TMA will contract with members to provide those representation services.

"The dues-paying member wants TMA to do this," Trustee Frederick L. Merian, MD, of Victoria, said before the board's unanimous vote.

Even as association staff work with Attorney General Cornyn in writing the rules that will implement the new law, TMA is gearing up for its newest member service. The start-up phase includes:

- Making enhanced managed care contract review services available to members;
- Offering arbitration services to mediate physician-health plan disagreements before they mushroom into larger conflicts;
- Collecting and disseminating extensive data on health plans, such as market share, financial stability, and enrollment trends; and
- Offering educational presentations on the new law's potential — and potential drawbacks — in conjunction with county medical societies.

The contract review and data collection are prerequisites to any physician group's successful use of the new law, says Louis J. Goodman, PhD, executive vice president and chief executive officer of TMA. "Reviewing the health plans' contracts provides the basis for any negotiation," Dr Goodman said. "It will not only indicate the issues they will negotiate but will also allow us to jointly devise the strategy we will take to the negotiating table."

When and if physicians decide they want TMA's representation services, TMA would work with the physicians and the local county medical society to develop the paperwork that must be submitted to the attorney general's office for each case. TMA would then represent the group throughout the joint negotiating process.

> "The attorney general's office is fully prepared to work with physicians on this new law. We expect additional rulemaking to be completed by the end of the year."

Potential clients

Independent, rural physicians in areas where managed care is just entering the marketplace and independent practice associations (IPAs) that are having difficulty negotiating with health plans would be the primary candidates to use this service, says Susan Night, TMA's director of health care delivery.

Bob Tollefson, executive director of Nacogdoches Area Physicians Association, says his 100-physician IPA is waiting anxiously to see exactly how the negotiating process will work and "to see how TMA is going to get involved." The IPA currently uses a "messenger model" to negotiate with insurers. Under that model, which was designed to provide some protection from antitrust prosecution, Mr Tollefson serves as the messenger between the physicians and the health plans. He cannot share information among the doctors in the group, and each individual physician must make his or her own decision about signing any resulting contract.

"We think we could get another

layer of protection if we were able to participate in this negotiating process as a part of [the new law]," Mr Tollefson said.

In rural Cuero, family practitioner Raymond R. Reese, MD, is excited about the prospect of physicians being able to sit together at the negotiating table. "Rather than them picking us off clinic by clinic or community by community, we will negotiate from a position of strength," he said. Dr Reese

Questions and answers on physician negotiation in Texas
By Donald P. Wilcox, JD, TMA general counsel

Q. In general, what is the difference between "joint negotiation" and "collective bargaining"?

A. In Texas, "joint negotiation" refers to a statutorily created process of state supervised and regulated negotiations between physicians and managed care organizations over the contractual terms and conditions in the delivery of medical and health care services. "Collective bargaining" is a type of bargaining between an employer and its employees that is supervised and regulated by the National Labor Relations Board (NLRB).

Q. The Texas Legislature this year passed Senate Bill 1468, the Physician Negotiation Bill. What approach does that new law take?

A. This bill authorizes state-regulated joint negotiations between managed care organizations and independent physicians and physician groups such as independent practice associations (IPAs) and groups of physician-run organizations. There is no stipulation that the physician be an employee of the managed care organization.

Q. What is the state action doctrine?

A. This is a court-developed doctrine of law that allows states, through clearly articulated laws and active supervision, to regulate what otherwise might be considered "anticompetitive" activity under federal law and not result in the participants violating federal law. The idea is that the need for state-supervised regulation of the activity outweighs the concern over the activity's effect on competition.

Q. What about the American Medical Association's new national negotiating organization for employed physicians? (See "AMA Preparing to Act, PRN," p 32.)

A. This is designed to assist physician employees who seek to negotiate with their employers. For example, in some states, health maintenance organizations (HMOs) can hire physicians. These physicians could, with the assistance of AMA, seek to address the terms and conditions of their employment. First, however, NLRB must approve their application to be designated as a "collective bargaining unit."

Q. Why can't something like that work for independent physicians? When it comes down to it, we almost "work for" the HMOs.

A. Nonemployees cannot bargain collectively under the authority of NLRB. If a group of "independent physicians" had a large majority of their patients controlled by a single managed care plan and the control over the practice was so extensive as to suggest that the physicians were, in reality, employees, it is possible that they could apply for and be certified by NLRB as a collective bargaining unit. An NLRB regional office, however, has ruled recently against such a request. That full board must now consider that recommendation.

Q. What exactly is Texas' prohibition on the corporate practice of medicine?

A. This is a court-developed legal doctrine designed to prevent lay or corporate control over the practice of medicine. The lay or corporate entity is not licensed to practice medicine. To allow it to do so would provide too much power over the person who has qualified to practice medicine through the education, training, and testing required to obtain a medical license. Also, the Texas Insurance Code expressly states that HMOs may not "regulate, interfere, or intervene in any manner in the practice of medicine or any healing art."

Q. Can't physicians join a labor union? Surely they have the power to bargain with the health plans.

A. Physicians may join a labor union. However, to be part of a collective bargaining unit, the physicians would have to qualify as nonsupervisory employees of the entity with which they seek to bargain. Many physicians supervise other employees and, in doing so, may not qualify to be part of a collective bargaining unit even though they themselves are also employees and members of the union. This rule is in place to ensure that the unit is truly representative of nonsupervisory employees.

Q. Can doctors strike under Texas state law?

A. An NLRB-approved collective bargaining unit could strike in accordance with NLRB rules. Independent physicians, generally, are free to sign or terminate contracts with managed care entities as they choose. If they are financially and operationally integrated, they may do so as a group.

Q. What is the Campbell Bill?

A. This federal legislation (HR 1304

adds that physicians in his small clinic are looking to TMA to give them the legal and negotiating expertise they lack.

Even as it signaled its approval for TMA to develop these new services, the Board of Trustees sounded an important warning: TMA must ensure that the association doesn't find itself taking sides with groups of physicians. That includes more than avoiding obvious situations in which a group of TMA members wants to negotiate with the physician owners or managers of a health plan.

Trustee Bohn D. Allen, MD, of Arlington, points out that because the new law allows no more than 10% of the physicians in a plan's service area to join together for negotiations, the large majority of physicians in a service area will be excluded from any particular negotiating session. One group's successful negotiation, he says, could significantly alter the local medical marketplace.

"We must be very careful, if we exercise this, that we not use this in a way that would tilt the market to the advantage of one physician group over another group," Dr Allen said.

Roadblocks along the way

Physicians, medical group managers, TMA staff, and health law attorneys watching the attorney general's rulemaking process, however, see several potential impediments that could limit the new law's usefulness.

A big concern, says Ms Night, is the expense physicians might face. This includes not only the fee that the attorney general would impose but also the costs of developing all of the information about the physicians' practices that would be necessary to submit the case to the attorney general for approval.

The information itself poses another problem. Once it is turned in to the attorney general's office, which is a state agency, the information becomes public record. Mr Tollefson says physicians would be reluctant to compromise the privacy of their financial records.

Ms Night says TMA will continue to urge the attorney general to keep the fees low and minimize the amount of practice information it will require up front. TMA's legal staff is researching possible solutions to the question of confidentiality.

Another obstacle grows out of what was the bill's primary selling point in the legislature: the negotiation process is voluntary for the health plan. After physicians have expended resources to develop their proposal and obtain approval from the attorney general to negotiate with a health plan, the plan can still choose not to negotiate. TMA General Counsel Donald P. Wilcox, JD, is concerned that health plans won't come to the table to negotiate.

"In 2001, we'll go back to the legislature and tell them we need some more teeth in this law," he said.

Improvements in the language of managed care contracts resulting from TMA's advocacy efforts during the last three sessions of the legislature and restrictions in the new physician negotiation law make one physician pessimistic it will have a profound impact on contractual negotiations. "Most of the truly onerous contractual problems have been dealt with over time by public pressure and physician demand. TMA has done a good job," said Austin neurosurgeon Clark Watts, MD, JD.

Furthermore, he says, the new law allows fees to be addressed only in limited circumstances.

Out of the gate quickly

Because the attorney general's office

> "We need to be ready to come out of the chute. We need to utilize this bill right away, lest our enemies say, 'This is worthless, they're not using it, let's overturn it.'"

introduced by Reps Tom Campbell [R-Calif] and John Conyers [D-Mich]) was filed in an attempt to carve out a new class of persons (physicians) with the authority to bargain collectively with HMOs and other health insurers. (See "Antitrust Hammer," February 1999 *Texas Medicine*, pp 48–50.) It would change federal antitrust laws to allow independent physicians to negotiate collectively with managed care plans just as labor organizations can bargain under the National Labor Relations Act.

Q. What is the legal status of resident physicians in Texas? Are they students or employees?

A. Residents are generally considered to be both students and employees. The Internal Revenue Service views residents as employees. However, for purposes of collective bargaining, NLRB historically has considered them to be students. A court case seeking to have the NLRB position reversed is pending. AMA has filed a brief in support of allowing residents to qualify for collective bargaining. New York and California have passed laws recognizing the right of residents to bargain collectively under their respective state laws. Texas has not adopted similar legislation.

probably won't issue final rules before December, the law will be in effect barely a year before the legislature returns for its next regular session in January 2001. This deadline pressure added impetus to the trustees' decision to provide the negotiation services.

"We need to be ready to come out of the chute," said Trustee Susan Rudd Wynn, MD, of Fort Worth. "We need to utilize this bill right away, lest our enemies say, 'This is worthless, they're not using it, let's overturn it.'"

Despite all the potential logistical and strategic bottlenecks in the new law's road to fruition, TMA leaders retain a sense of satisfaction in maintaining Texas' role as the nation's leader in progressive health care legislation. "Probably the most important part of passing this bill is not what we're actually going to do with it, but that we have the right to do it," Dr Allen said. ★

Steve Levine can be reached at (800) 880-1300, ext 1380 or (512) 370-1380; or by e-mail at steve_l@texmed.org.

AMA preparing to act, PRN

Despite, or perhaps because of, the intense publicity surrounding the American Medical Association House of Delegates' June vote to create a national negotiating organization, the AMA Board of Trustees is taking steady — but decidedly deliberate — steps to implement that decision.

Physicians for Responsible Negotiations (PRN) is the AMA body that will represent employed physicians in contract negotiations with health plans. AMA officials say PRN will represent any physician group whose members are eligible under the law — mostly employed physicians who are not supervisors or managers — and who "show a real commitment to move forward in an organizing activity."

"We will not go out there and actively organize physicians, but we will be there if they need us," AMA President Thomas R. Reardon, MD, told Texas physicians at TMA's 1999 Fall Conference. "We will not strike, we will not withhold care. This is not a traditional labor union."

Dr Reardon said he and his fellow hometown physicians in Portland, Ore, where three health plans dominate the marketplace, are feeling the same "extreme frustration and feelings of helplessness" that prompted the AMA House of Delegates to take action. "I have no clout and no influence; I can't walk away from those contracts," he said.

Part of the preamble of the new organization's constitution states that PRN will "advocate on behalf of our members, with their employers and others, as the law allows, to create and maintain a health care system that guarantees all our members a working atmosphere where they can devote the time and attention their patients need."

In September, the AMA trustees named 5 members to serve on PRN's governing body. They will select the remainder of its governing committee, which is expected to number between 9 and 12. Serving on the PRN governing board are:

- AMA Trustee Susan Hershberg Adelman, MD, a pediatric surgeon from Southfield, Mich;
- AMA Trustee John C. Nelson, MD, an obstetrician and gynecologist from Salt Lake City, Utah;
- Former AMA Trustee Andrew Thomas, MD, an internist from Columbus, Ohio;
- Ross Rubin, an attorney and AMA vice president for legislative affairs; and
- Todd Vande Hey; AMA vice president for private sector advocacy.

After AMA forms a legal corporate entity for PRN, it will announce that PRN is open to receive physician requests for information and assistance. AMA also will undertake a campaign to educate physicians on their negotiating options.

For independent physicians, AMA is continuing its three-pronged approach of aggressive advocacy with the health plans, helping states pass laws like Texas' new Physician Negotiation Act and lobbying for national antitrust relief.

Although Congress had taken no action at press time, support continues to grow for the Quality Health Care Coalition Act of 1999 (HR 1304 introduced by Reps Tom Campbell [R-Calif] and John Conyers [D-Mich]). The so-called Campbell Bill would change federal antitrust laws to allow independent physicians to negotiate collectively with health maintenance organizations and other health insurers just as labor organizations can bargain under the National Labor Relations Act. The bill prohibits strikes and other actions that would interfere with patient care.

PRN will be able to represent self-employed physicians under the Campbell Bill, should it pass.

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BACK TO THE BORDER

TMA HELPS IMPROVE HEALTH CONDITIONS ALONG THE RIO GRANDE, BUT MORE NEEDS TO BE DONE

By Laura J. Albrecht, TMA public information officer

"FANTASTIC!"

A satisfied smile as long and wide as the Rio Grande appears on the face of native El Paso pediatrician Laurance N. Nickey, MD.

The green grass and plants at the entry of the Centro Comunitario de Sparks seem a tad out of place considering that the sparkling brick building is in the middle of the Chihuahuan Desert near El Paso. And to some, even the squeals of children playing on the blue and yellow playscape may sound out of the ordinary, given the area's extreme poverty. But to Dr Nickey, who has spent his life in the "other Texas," these are sights and sounds of progress in a land where for many families each day is a struggle to survive.

It's Wednesday morning and that means health care services are available to the 4,000 families who call the Sparks *colonia* home. More than 150 *colonias* (pop-up communities with substandard housing and little or no access to water, wastewater disposal, or electricity) with a population of about 72,000 exist in El Paso County. On this day, pediatrician Carlos Gutierrez, MD, has a full list of patients. With the goodwill and dedication of other volunteers, including his wife, Martha, the residents will receive medical attention that once was nonexistent.

"The moms and their kids walk in from the desert because they know there is going to be a pediatrician here on Wednesday," Dr Gutierrez said. "This brings me back to why I am a doctor."

Dr Nickey scans the exam rooms and the outdoor playground with an understanding of the significance of this clinic in the community and the care Dr Gutierrez provides on a weekly basis. Before leaving, Dr Nickey stops to talk with a young man who proudly announces he is going to college. Like a beaming parent, Dr Nickey shakes his hand and adds a hug.

"This is what medicine is all about," he said. ➤➤➤

Journey along the border

In August 1989, the Texas Medical Association and the Texas Department of Health hosted the Border Health Conference in El Paso. Physicians, along with local, state, national, and international government officials, and representatives from medical schools, medical associations from New Mexico, Arizona, and California, and the American Medical Association attended. Their hope was to carry out a mission that would bring the basics of public health — clean water, proper disposal of waste, and improved health care — to the region. The grand plan was to urge Congress to establish a US-Mexico Border Health Commission.

In 1994, President Clinton signed the bill creating the commission. However, at press time, Mexico had not agreed to participate in the commission and had not appointed its members. Mexican officials are concerned with language in the bill that requires the United States and Mexico to reimburse each other for the cost of treating each other's citizens when they travel across the border. TMA plans to lobby Congress to remove that requirement.

Ten years after that El Paso conference, the question arises: has the blood, sweat, and tears of TMA leadership, membership, and staff improved life on the border?

Dr Nickey, former head of the TMA Council on Public Health, best sums up the answer. "The Texas Medical Association has made an enormous difference. TMA is responsible for getting the ball rolling and pushing it forward. TMA deserves two thumbs up."

But the issues that have haunted the border for decades remain: ravaging infectious diseases; raw sewage pouring from homes; water unfit to drink by man, woman, child, or beast; poverty; and illiteracy.

"We have a long way to go," Dr Nickey said. "It's never-ending, and we have a lot of work to be done."

Living the border life

Mario Hernandez wheels the well-traveled, white government van down I-10. To his left is the Rio Grande or Rio Bravo. "This river is like a seam between two communities," said Mr Hernandez, a public health technician with the El Paso City-County Health and Environmental District.

The river, which does not divide but unites two countries, stretches from Brownsville to El Paso. For some, it is a playground. To others, it is a source of water for livestock, crops, and families. And to many, it is a trail they hope will lead to a better life.

Name it, and it's found a place on the border: diabetes,

"The Texas Medical Association has made an enormous difference. TMA is responsible for getting the ball rolling and pushing it forward."

Laura J Albrecht

The Border Health Initiative aims to improve conditions in the *colonias* that dot the border, like this one near El Paso.

The making of a border health commission

May 1988
County medical societies along the Texas-Mexico border submit resolutions to the Texas Medical Association House of Delegates requesting TMA to ask the Texas congressional delegation to urge Congress to establish a commission to assist Mexico and the United States in planning, developing, financing, and implementing health programs in communities on both sides of the border.

June 1988
TMA requests the American Medical Association to support the commission.

Laura J. Albrecht

"You cannot understand the border unless you live it. For the purposes of public health it is interacting every day every hour, and every minute with both sides of the river What affects one side affects the other."

The Rio Grande snakes along the Texas-Mexico border for 1,000 miles and unites two countries

chicken pox, tuberculosis, measles, hepatitis A, cholera, rabies, anencephalic births, AIDS, air pollution, and frivolous lawsuits. And, if you call El Paso home, you live in a different time zone than the rest of the Lone Star State.

"You cannot understand the border unless you live it," said Dr Nickey, a member of the US-Mexico Border Health Commission. "For the purposes of public health, it is interacting every day, every hour, and every minute with both sides of the river. What affects one side affects the other."

Visible signs of progress exist, even though many tasks remain to be tackled in the region:

- A half-million-gallon water tank towers above the homes where residents of *colonias* once pumped water into discarded industrial barrels from a single wellhead.
- Blue-topped water mains dot the roads, and sewer lines are being laid, but residents still must pay for hookups to their homes. A paved neighborhood street intersects a dirt path.
- Immunizations are on the rise.
- A major copper smeltering plant on the border has closed, providing some relief from air pollution.
- Public health workers and an army of volunteers pound the dirt and pavement to alert more than 14,000 households about the importance of sanitizing water and washing hands before preparing food and eating.

In addition to these tangible examples of progress, the efforts of TMA and others have raised awareness of the region's problems, and likely will lead to even more progress in delivering the basics of good public health — clean water, fresh air, waste disposal, and immunizations — to the area.

There is no question that many problems remain.

The entire border population is projected to double by 2025. An already overstressed infrastructure on the border, which has nearly 400 million crossings a year, will face even more challenges. El Paso's sister city across the river, Juarez, has more than 1 million residents, but no wastewater plant. The city dumps millions of gallons of raw sewage and industrial waste into *Agua Negra*, approximately 200 to 300 yards south of the Rio Grande. Much of that water is pumped into the farmland to irrigate cotton and alfalfa. However, it sometimes flows into fields of beans, cabbage, tomatoes, lettuce, and chilies. What isn't used for irrigation is directed into the Rio Grande.

On the eve of 2000, disease, fire, and flood still threaten the health and safety of families in the *colonias* on both sides of the border. "There have been disastrous fires in the *colonias*

The making of a border health commission

September 1988
The TMA Council on Public Health agrees that TMA is in a unique position to address border health problems. The council makes border health its primary focus and agrees an international body would have the appropriate jurisdiction and necessary resources to solve the problems.

June 1989
The AMA Council on Scientific Affairs issues a report acknowledging that current solutions to border health problems are "inadequate, fragmentary, and are not coordinated by the two nations." AMA agrees a permanent US-Mexico border commission is "essential to deal with this major threat to the health of both nations."

ear the federal prison in Juarez," Dr Nickey said. "Cardboard onstructed houses were destroyed because of high winds nat fueled the flames and lack of water to fight the blazes."

The border's problems have "been going on for decades,")r Nickey said. "What we have to remember is that people re coming from Mexico, Central America, South America, nd points beyond to the border to survive. The *maquila* industry along the border is a magnet for these folks. If they an't get work in the factories, then they'll cross the border nto El Paso, the Rio Grande Valley, Laredo, or Del Rio. And they can't find work there, they'll migrate to Chicago, New ork, San Francisco, or wherever they can get jobs."

Classic tale from the border

n 1986, a young man from the Environmental Protection gency (EPA) arrived on the border in El Paso to investigate eports of the city's noncompliance with air quality regulaions. He visited on a cold winter day when snow dusted the esert floor. The director of the El Paso health department ook him to the riverbanks where Pancho Villa and Gen John Black Jack" Pershing once roamed.

The government official looked across the river and saw tiny *asitas* with smoke curling upward to 100 feet and layering the esert mountain community's sky. He looked to the health director and demanded to know why he didn't do something about he pollution. The health director informed him that the mothers n those homes were building fires to keep their babies from reezing, and they live in Mexico. He then reminded the EPA official that he didn't have any authority to enforce US laws in a oreign country.

"Honest to God, his jaw dropped in amazement," Dr Nickey ecalled. "He just did not understand." Six weeks later, a letter rrived from the EPA stating it was very possible that the El Paso irshed could be affected by a nearby foreign country — end of tory, but not an end to the problems. Everything changes, and nore changes will come to the border. (See "Environmental Health Issues Along the United States-Mexico Border: An Airhed in Evolution," October 1999 *Texas Medicine,* pp 58–59.)

"Folks along the border have hope," Dr Nickey said. When you have hope, good things can happen. But if you give up hope, you are doomed." ★

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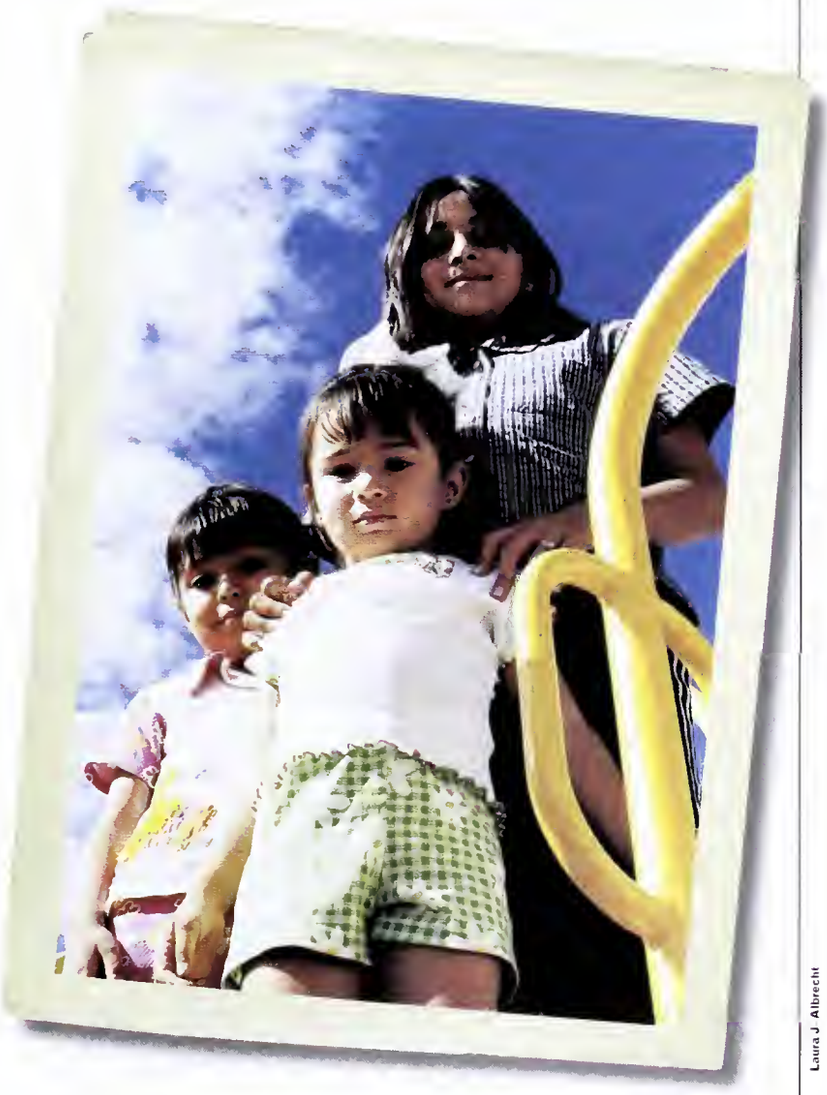
"Folks along the border have hope. When you have hope, good things can happen. But if you give up hope, you are doomed."

Efforts to improve health conditions along the border may mean a brighter future for children like these at the Centro Comunitario de Sparks.



Laura J Albrecht

August 1989
The first Border Health Conference, sponsored by TMA, is held in El Paso. All four border states — Texas, New Mexico, Arizona, and California — and AMA are represented. More than 200 participants attend, and a joint letter is sent to border state lawmakers urging support for the commission.

November 1990
The second Border Health Conference, sponsored by the California Medical Association, is held in San Diego. It is cosponsored by medical associations in Texas, Arizona, and New Mexico. The conference focuses on scientific issues and sharing of health data among the states.

The year of the border

New laws promise help to improve health along the Rio Grande

By Ken Ortolon, Associate editor

When the 76th Texas Legislature convened in January, Texans living along the Texas-Mexico border had high hopes that many of their most pressing concerns might finally be addressed in Austin. After all, a convergence of political interest from top state officials promised to focus a tremendous amount of legislative attention on the region.

For once, they were not disappointed. When lawmakers packed their bags and headed home at the end of May, they left behind a body of new laws that promises to be a boon for the border. And health care, in particular, appears to be a major winner.

"It was an extremely good session for the border in that it provided a number of bills that will improve health care delivery along the border and help identify specific health care and medical training needs in the region," said Gayle Harris, Texas Medical Association's director of public health.

Getting their attention

Indeed, conditions were ripe for major progress not only on health but also on broader infrastructure problems that play a major role in health problems along the border. Before the 76th session, Gov George W. Bush appointed his secretary of state, Elton Bomer, as his border liaison and directed him to investigate the infrastructure needs of the region. By the time the session convened, Secretary Bomer had made several fact-finding trips to the border and drafted recommendations to address water, wastewater, and other infrastructure needs in the *colonias*, the substandard housing developments that dot the border region from El Paso to Brownsville.

On top of the interest exhibited by Governor Bush and Secretary Bomer, Lt Gov Rick Perry appointed a special Senate Border Affairs Committee made up of several border area senators and influential senators from other parts of the state. Most of the key border issues were funneled through and got quick action from the committee.

Senator Eddie Lucio (D-Brownsville), who chaired the Border Affairs Committee, points with pride to several bills that will directly impact public health and health care delivery in the region. Among them are two bills that TMA worked closely with Senator Lucio and others to enact. The first, Senate Bill 1378 by Sen Eliot Shapleigh (D-El Paso), directs the Texas Higher Education Coordinating Board to conduct a study and develop recommendations on medical training needs for health professionals in the border area. The recommendations will be based on a Texas Department of Health assessment of future border medical and health care services, and other needs requirements for the area.

The second, House Bill 2025 by Rep Joseph Pickett (D-El Paso), creates a Border Health Institute in El Paso. The institute was given $50 million from the state's tobacco lawsuit settlement to research public health issues affecting the border region, such as diabetes, infectious diseases, and environmental health issues. It also will deliver health care and provide health education to border residents.

Former TMA President Wm Gordon McGee, MD, of El Paso, says the border institute has the potential to benefit the border community. "This will be a local, community-guided institution that is going to be able to prioritize some of the needs that we have on the border and have access to funds that will help us develop programs to address those needs."

Among other measures that passed were bills to build a new facility to replace the existing South Texas Hospital in the Rio Grande Valley, establish a statewide hepatitis C edu-

The making of a border health commission

October 1991
The third Border Health Conference is held in McAllen. The impact of economic and public policy issues is discussed. Representatives from the business community attend.

November 1991
The TMA House of Delegates approves a resolution to AMA requesting that legislation be drafted and introduced in 1992 to enact the establishment (along with funding) of a US-Mexico Health and Environment Commission. AMA approves the resolution in December.

cation and prevention program, allow counties to create multicounty health services districts to provide indigent health care, and require schoolchildren in a 32-county area within 60 miles of the border to have hepatitis A vaccinations.

"This is an important issue on the border," Senator Lucio said. "We know the risk of being infected with hepatitis A really depends on hygienic and sanitary conditions. Unfortunately, the lack of sanitary conditions along the border has resulted in numerous outbreaks of hepatitis A."

Making the connection

Actually, the lack of sanitary conditions has resulted in near epidemic rates of many infectious diseases almost nonexistent elsewhere in Texas and the United States. Senator Lucio's own bill, SB 1421, addresses this problem. It creates a *colonias* ombudsman program that will help focus attention on border infrastructure problems and ensure that state and local resources are properly directed toward resolving them. The concept came from Secretary Bomer's recommendations.

"By focusing attention and resources on these problems, we can attack many of the things that have contributed to high disease rates along the border, including sewage, housing, and an array of other factors," Senator Lucio said.

Scott Storment has been hired to serve as *colonias* coordinator within Secretary Bomer's office. He will oversee six *colonia* initiative advocates who will be located in the six counties with the largest *colonia* populations — El Paso, Maverick, Webb, Starr, Cameron, and Hidalgo.

Mr Storment says these advocates will be the "eyes and ears" of the secretary of state and the Governor's Office. "They will act as troubleshooters to make sure that water projects, wastewater projects, solid waste projects — anything that goes back to serving *colonia* residents and getting rid of public health issues in the *colonias* — are meeting their time lines and that services are being delivered."

In addition to creating the *colonias* advocates, SB 1421 also eases restrictions that have prevented government agencies from providing services to illegally platted subdivisions. Mr Storment says these are the "worst case scenarios for public health issues," but the state and local governments could do nothing about them because of the previous restrictions.

Meanwhile, Secretary Bomer is backing up the ombudsman program with the Texas Plan, an effort to raise $25 million from a variety of sources, including the North American Development Bank and Texas Water Development Board (TWDB), to actually connect homes in border *colonias* to existing or future utility services.

"By focusing attention and resources on these problems, we can attack many of the things that have contributed to high disease rates along the border, including sewage, housing, and an array of other factors."

While the state has pumped hundreds of millions of dollars into utility construction in the region over the past decade, TWDB policy has prohibited it from using its funds to pay for the actual connections to water or sewer lines. The Texas Plan will target connecting 25,000 homes to water and sewer services in 13 border counties. That could impact as many as 100,000 *colonia* residents.

Continuing the effort

While major strides were achieved for the border this session, the work is not finished. In September, Lieutenant Governor Perry directed Senator Lucio's committee to conduct an interim study of health problems, infrastructure needs, and economic development issues on the border. The committee will make recommendations for lawmakers to consider in the next session on issues such as the border region's water and wastewater systems and their impact on public health. The panel also will look at health conditions endemic to the border, including diabetes and tuberculosis.

The interim recommendations are due by September 1, 2000. The 77th Legislature convenes in January 2001. ★

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Spring 1992
AMA drafts a bill that is sent to state medical associations for review and input.

January 1993
"Border States' Strategies for the US-Mexico Health and Environment Commission" conference is held in Tucson. The conference focuses on reviewing the draft legislation, setting out the required components of a border health commission, and building a consensus among the four border state medical associations.

Keeping disease at bay

A dengue fever outbreak in Laredo follows the typical complexities of disease along the border

By Monica Maldonado, Associate editor

That health officials suspect discarded tires could be the genesis of a dengue fever outbreak in Laredo during the summer illustrates how precarious the health situation is along the Texas-Mexico border. Lacking resources and mired in the bureaucratic nightmare of having to coordinate local, state, and federal efforts of two countries, border health programs struggle with the same communicable and infectious diseases faced by the rest of Texas, as well as diseases most in the United States would consider Third World. Public health officials count on educating the community and avoiding disease altogether to improve overall health.

The tire story is uncommon, even for this region, but not surprising. Physicians and health care officials along the border have seen dengue fever before. The Rio Grande Valley saw 29 cases in 1995. In 1980, Laredo had 27 patients with confirmed cases, none of whom had traveled outside the United States. Symptoms of the tropical disease include fever, severe headaches, joint and muscle pain, nausea, and vomiting, maybe even a rash. A more severe dengue, which causes massive internal bleeding, can be fatal.

But tires obviously don't cause dengue fever. It is transmitted via the bite of the *Aedes aegypti* mosquito, an annoying little bugger common in wetter Central America that feels very comfortable laying eggs in small, shady pools of standing water, which are created quite nicely in the cupping curves of discarded tires.

A 1992 Texas law requiring the recycling of discarded tires was successful and had an added bonus of diminishing the number of mosquito nesting grounds. But that law, of course, did not apply to Mexico. "Historically, the management of waste on the other side of the border has been a problem," said Mary Wright Eyster, a tire program specialist with the Texas Natural Resources Conservation Commission.

The law required tire sellers to charge $2 for each tire their customers exchanged for new ones. The state comptroller collected the money and paid transporters to take the tires away. The transporters then paid shredders to take the tires, and the shredders sold the scraps for use in cement kilns or road engineering projects. The transporters were paid only when the tires were recycled.

But at the end of 1997, the state stopped collecting the $2 and stopped paying tire transporters. Now the system is privatized, and tire sellers must pass on the $2 — or whatever the market will let them collect from customers — to the transporters, who in turn must pay for the disposal. "Chances are if you see a major pile of tires, they've most likely been dumped by the transporter who doesn't want to pay for their disposal or shredding," Ms Eyster said.

The law was never intended to be a permanent solution to the tire problem. Now, tire dumping, especially along the border, might again be on the rise simply because the area has always been plagued by illegal dumping and other environmental hazards, and because the distance to tire shredders is too far for transporters. The frequent rains of early summer couldn't have hurt these mosquito nurseries. Add in the close-quarters living arrangements, the large numbers of people crossing between Laredo and Nuevo Laredo, and the myriad other types of water-collectors — including some uncovered *colonia* water supplies — and you have a good chance for an outbreak.

"I don't think it is a coincidence," said Victor Oliveros, chief of health protective services for the Laredo Health Department. "Until August, Nuevo Laredo and Laredo had a rel-

The making of a border health commission

January 1994
Laurance N. Nickey, MD, of El Paso, testifies before the Subcommittee on Health and Environment of the Committee on Energy and Commerce in Washington, DC. He offers testimony supporting HR 2303, which calls for establishing a US-Mexico Health and Environment Commission. Letters of support for the commission are secured from border network members. Press conferences are held in cooperation with Hidalgo-Starr County Medical Society and Nueces County Medical Society to provide legislative updates.

October 22, 1994
Public Law 103-400, which establishes the US-Mexico Border Health Commission, is signed by President Clinton.

atively dengue-free ride." Mr Oliveros says about 200 cases of dengue (some unconfirmed) in Nuevo Laredo and 16 in Laredo have occurred this summer.

In response, the City of Laredo has been urging residents to empty, cover, or turn over all standing water containers. "It's mainly education," said Mr Oliveros. "Our next push is to talk to schoolchildren about what they can do at home about standing water." Meanwhile, trucks roll through the streets in the early morning, fogging neighborhoods with malathion. The Centers for Disease Control and Prevention is analyzing the dengue outbreak further.

Prevention and treatment

An environmental or social problem turns into a health problem that spans two countries, each with a different way of dealing with it. Health officials combat the problem with education to keep the outbreak at bay and do their best to treat the symptoms case by case. To treat the cause of the outbreak — in most cases, poverty — would require a finance system so that all border residents could afford health care. Lacking this, health officials along the border stress education and prevention in each of their specific programs.

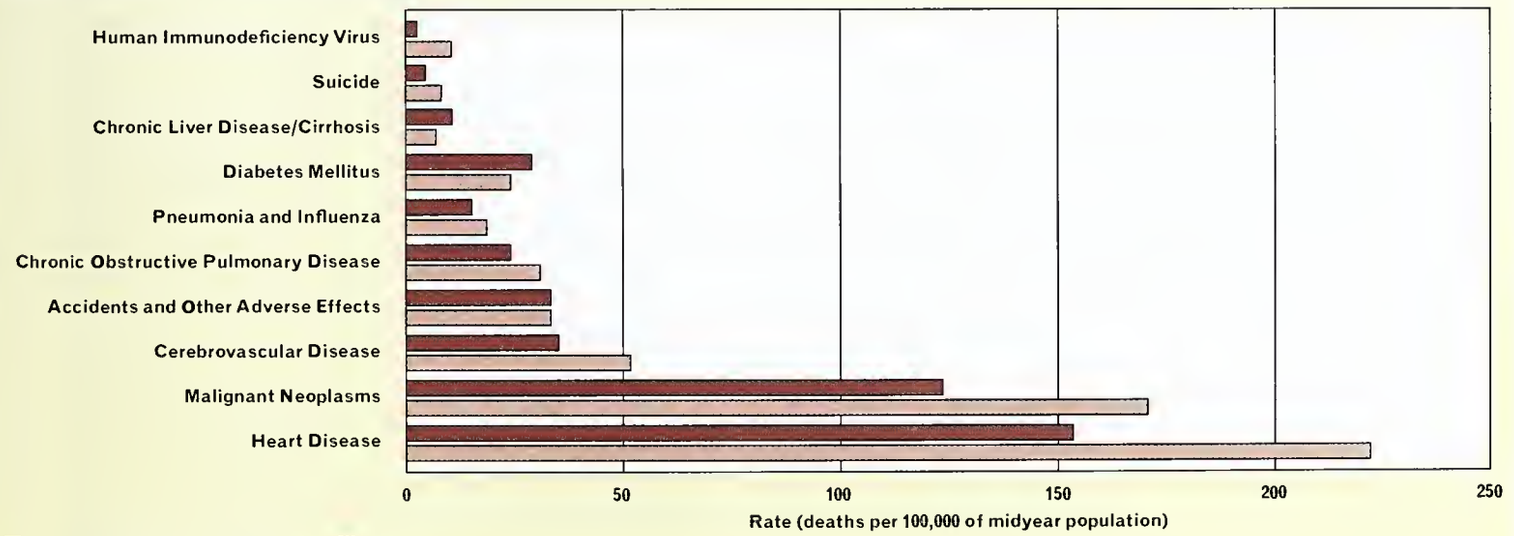
Coordinating efforts with Mexico is a continuing problem for border health officials. Usually, needs are addressed on a case-by-case basis. Brian Smith, MD, public health director of the Texas Department of Health's Region 11, says Texas and Mexico are working on binational programs to fight tuberculosis and neural tube defects, for example. "It's important for us to work with Mexico on these problems," he said, "because they have the capacity to treat all these cases."

Laredo's response to the dengue fever outbreak may seem reactive, but in reality preemptive education and prevention efforts are strong along the border. The biggest push in battling drug-resistant tuberculosis, for example, is in teaching patients the importance of taking their medications for at least 6 months, not just to the point when they can no longer afford it. Of course, that advice ignores the problem of how the patients are supposed to pay for it. Dr Smith says new legislation to allow counties to work together and share resources might help.

Dealing with diabetes

In one case, however, education and prevention are perched to make a great stride. Diabetes is a monster on the border; in the four-county Rio Grande Valley alone, type 2 diabetes has hit about 20% of the population. An even scarier fact, found by the American Diabetes Association, is that type 2 diabetes in children is taking on epidemic proportions.

Death rates for Texas and selected Texas-Mexico border counties, 1995.



Data developed by the UT System Texas-Mexico Border Health Coordination Office

January–December 1997
TMA President Phil H. Berry, Jr, MD, meets with Mexican officials to discuss concerns with implementation of the commission. The commission receives a one-time allocation of $800,000. The process of naming members to the commission begins.

April 1998
TMA facilitates a meeting with leaders from the United States and Mexico to discuss further implementation of the commission. El Paso County Medical Society asks TMA to aggressively support federal funding of the commission.

Paul Villas, PhD, head of The University of Texas System Border Health Office in Edinburg, believes he has found a way to detect type 2 diabetes in children. He has begun a program to screen children in nine border counties for acanthosis nigricans, a skin condition he says is associated with insulin resistance. "We call it the Antes Project," Dr Villas said. *Antes* means "before" in Spanish. "It's a fitting name because we think we can do something about this condition before type 2 diabetes becomes a reality for these children."

Dr Villas' efforts in this area led the Texas Legislature to pass a bill this year mandating screening for acanthosis nigricans.

The program will enlist the efforts of school nurses trained and educated to look for the brownish skin marker, which usually occurs on the neck or axillae. Students determined to have the marker will receive a recommendation to their physicians for glucose and insulin screenings. Dr Villas says that so far children with the marker have left their doctors' offices without screenings but with recommendations to shampoo with Selsun Blue. "We hope to educate area doctors on the relationship between acanthosis nigricans and diabetes," he said.

Dr Villas strongly believes social problems, not genetic predisposition, have caused the rise in type 2 diabetes in kids. "There is not a diabetes gene in Mexican Americans," Dr Villas said. "The body is like a car. And every car is wired differently for different types of fuel," he said. "When you give a body the type of fuel it's not supposed to have, things are going to go wrong."

He points to diet and lack of exercise to explain the rise in diabetes cases. "The typical daily drink around here is a 20-ounce cola. School districts should ban the machines in our schools that dispense sugar drinks," Dr Villas demanded.

One of the goals of the Antes Project is to encourage area physicians to look for early signs of type 2 diabetes and to teach children that their behavior and food choices affect their health.

"It won't be uncommon in the coming years to see a 20-year-old double amputee," said Dr Villas. "This is what drives me. I want people to see this project going on in the Valley and get the idea that we can turn things around for the better health of these people." ★

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State of the Border

If the 43-county border region were a separate state, how would it (the "Border") rank compared with Texas and the other 49 states in terms of key health and social factors? This illustration is based on rankings compiled by the Texas Comptroller of Public Accounts in 1998. (The comptroller considers the Border to include those counties along and south of Interstate 10, then along and south of Interstate 37.)

The Border's rank among the "51" states	Texas' rank among the 50 states
Population, July 1996	
24th with 3.9 million	2nd with 19.1 million
Total area, 1990	
16th with 79,423 square miles	2nd with 267,277 square miles
Poverty rate, 1993	
1st with 29.5%	6th with 19.6%
Unemployment rate, 1997	
1st with 8.0%	10th with 5.4%
Death rate (per 100,000 population),1995-1996	
48th with 652.0	45th with 735.7
Death rate from hepatitis and other liver diseases (per 100,000 population), 1995	
2nd with 14.3	15th with 10.0
Death rate from diabetes (per 100,000 population), 1995	
3rd with 30.2	17th with 24.4
Infant mortality rate (per 1,000 live births), 1995	
40th with 6.3	39th with 6.5

The making of a border health commission

March 1999
President Clinton appoints Dr Nickey and Paul Villas, PhD, to the commission.

August 1999
Creation of the US-Mexico Border Commission is threatened when US State Department officials recommend President Clinton issue an executive order creating a federal advisory council in place of the commission because Mexico had not agreed to participate. TMA, the Texas Department of Health, the California Medical Association, and others immediately oppose the State Department recommendation on grounds the advisory council would lack necessary funding and would be in existence for only 2 years. At press time, President Clinton had not issued the order. TMA is continuing to try to persuade Mexico to participate in the commission.

Commentary

Clean water for the *colonias*

By Elton Bomer, Texas secretary of state

A quote in a recent *San Antonio Express-News* story perfectly summed up the chief public health concern plaguing our state's border *colonias*: "Water, water, water — that was the problem," said a director at the Laredo Health Department.

The local official was referring to flooding from Hurricane Bret that ultimately may help spread dengue fever. The flooding and resulting standing water provided a welcome home to the mosquitoes carrying the dengue fever virus.

Yet even bigger problems lie in the *colonias* on either side of Laredo — contaminated pools of standing water and lack of access to fresh water. Put more simply, untreated drinking water and wastewater increase the risk of disease.

According to the Texas Department of Health, people in border counties with a high number of *colonias* have a higher rate of hepatitis A, salmonellosis, and shigellosis infectious diseases, all associated with untreated water and poor sanitation. This is a special danger to the most vulnerable residents — young children and the elderly.

Studies show hepatitis A virus rates stem, in part, from contaminated drinking-water containers and inadequate disposal of human waste. For instance, more than 20% of the stored water samples of four El Paso *colonias* reviewed for a 1997 study by researchers at The University of Texas contained *E coli*.

Many homes in *colonias* do not have individual connections to water mainlines, although more have water line connections than have sewer line connections. And, as the researchers in the UT study pointed out, even residents who live in homes with water and sewer connections remain at risk for disease from neighbors' homes without connections.

The lack of healthy living conditions in *colonias* is caused by many factors. Texas historically has used state and federal dollars to install the mammoth water and sewer mainlines buried underneath main streets in *colonias*. However, securing funds to help residents pay for individual connections to their homes has been, at best, slow in coming. Most *colonia* homeowners have been unable to afford the estimated $2,000 to install individual water and sewer connections.

As of January, only an estimated 14,200 individual connections had been installed in *colonia* homes, though Texas has invested more than $500 million in water and sewer mainlines over the past decade.

That's where I came in.

Recently, I announced the Texas Plan, a water and sewer connection program to complete a decade of work by the Texas Water Development Board (TWDB) and the Environmental Protection Agency to provide mainline infrastructure to hundreds of *colonias* in the Texas border region. The effort is the most extensive *colonia* water and sewer connection plan in Texas history.

The program is a $25 million initiative to fund individual water and sewer connections for about 25,000 homes — about 100,000 *colonia* residents — along the Texas-Mexico border. The funding will come from the North American Development Bank, the TWDB, and the Texas Department of Housing and Community Affairs.

We also will make inroads because of Senate Bill 1421, passed by the 76th Texas Legislature and signed by Gov George W. Bush, which removed bureaucratic laws that actually prevented progress from being made in the *colonias*. Never before in Texas history has there been such bipartisan support for a *colonias* measure. The bill contains revisions concerning water and wastewater service to *colonias*; enforcement and compliance with laws to limit *colonia* proliferation; and coordination of *colonia* policies among state agencies and local governments.

William R. Archer III, MD, an accomplished physician and current commissioner of the Texas Department of Health, says the *colonia* legislation reflects both the approach and long-term solution that public health officials can support.

Dr Archer says he believes SB 1421 will improve the infrastructure necessary to provide an ongoing supply of clean water for *colonia* residents.

The legislature has spoken, and state agency and public health officials have their work cut out for them. But I know their commitment is strong and their expertise sound. I am confident that work in the secretary of state's office and among all state agencies will progress swiftly and in unison as we endeavor to bring the most basic of needs to *colonia* residents — water, water, and yes, more clean water. ★

Secretary of State Elton Bomer is a senior advisor and lead liaison for border and Mexico affairs for Gov George W. Bush.

Mercy missions

Texas physicians reach around the world to touch patients in need

The skinny 8-year-old boy with a severely deformed cleft palate plays on a mat most of the day in a tiny hovel in San Salvador, El Salvador. Because of the birth defect, he is shunned by the rest of the community, and his parents have removed the mirrors from their home so he will not be reminded of his affliction.

During a recent medical mission, the boy was 1 of 79 patients receiving life-changing reconstructive surgery from Austin Smiles, a group of volunteer surgeons, anesthesiologists, nurses, operating room technicians, and interpreters.

Stankovic 1 and Stankovic 2 are tent cities, each housing 20,000 Kosovar refugees 3 miles inside Macedonia's border. Each camp has a makeshift medical center where 400 to 800 patients a day receive medical treatment. Run by the International Medical Corps (IMC), the centers are not equipped to do much more than treat the skin problems and parasitic diseases that ravage the people there.

Medical teams, made up of local and foreign physicians and nurses, refer more serious cases to hospitals in other countries. Drug choices are few, and little testing is available. The American physicians who are putting in 12- to 24-hour shifts often can do little more than listen as their patients talk — through translators — of seeing family members murdered and their homes destroyed.

A line of patients flows through the gates of the Hermano Pedro Hospital just outside Antigua, Guatemala, in the early morning. Some have traveled 5 or 6 days on foot. A primitive communication system of printed fliers and word of mouth lets them know when the American surgeons will arrive.

A mission of physicians, operating room personnel, and triage volunteers, one of five planned this year by Faith in Practice, will spend 8 challenging days, providing much-needed free medical and surgical care in a country where such care is usually unavailable.

The ORBIS flying surgical fortress rests majestically on an airport tarmac in Amman, Jordan. Inside the specially equipped DC-10, physicians treat patients for cataracts and perform corneal transplants and other reconstructive surgeries. Multiple cameras transmit each procedure to outlying hospitals where local surgeons gather to observe and learn. Through interactive technology, they ask questions throughout the procedure.

Host countries invite ORBIS teams to visit, and local surgeons select candidates for surgery. US surgical teams fly to the site on Sunday evening, spend Monday screening patients and then long hours Tuesday through Friday operating and teaching on the plane.

By Alice Adams

A mother in El Salvador brings her baby to the Austin Smiles medical team for surgery to correct a cleft palate.

Mirror, mirror on the wall

Austin Smiles medical missions have visited Brazil, the Philippines, Mexico, and Equador, but since 1992 most of them have returned to El Salvador. "This is the most densely populated area of Central America, and during our first trip, we learned the area had been involved in a civil war and had a backlog of about 3,000 cleft lips that needed treatment," said James Cullington, MD, an Austin plastic and reconstructive surgeon and president of the Texas Society of Plastic Surgeons.

Dr Cullington, along with Drs Pat Beckham and James Fox, cofounded Austin Smiles about 12 years ago. "Each of us had just returned from medical missions and were talking about ways of uniting plastic surgeons while at the same time doing something of value," Dr Cullington remembered.

"When we took the idea of a medical mission to our society, they said yes, and for the first few years, we all contributed about $60,000 to get things going. Then we began involving anesthesiologists, pediatricians, emergency room physicians, family practitioners, and then nurses, scrub techs, and volunteers. Today, we make three major trips annually, plus we offer to correct the cleft palate and cleft lip deformities in about 700 children born in Austin each year, regardless of the parents' ability to pay."

During each mission, scores of volunteers give up vacation time to take part in an exhausting marathon of up to 83 cases, depending on the availability of surgeons and facilities.

The efforts of Austin Smiles, one of the few programs returning to a single destination, have been measured by its grateful patients' improved lives, through national recognition by the Reconstructive Surgeons for Volunteer Programs, and by being named one of President George Bush's "Thousand Points of Light."

"Because of your surgeries to repair the faces of young and old alike, families have been allowed to put up mirrors again."

Dr Cullington says the program allows him "to give the one talent I have with no strings attached to people who need it and deserve it and who acknowledge us for the work we've done, sometimes with a smile, sometimes by just squeezing my hand."

Last summer, before the group left San Salvador, a young woman gave the surgeons beautifully hand-painted mirrors. "Because of your surgeries to repair the faces of young and old alike, families have been allowed to put up mirrors again," she said. "We offer these mirrors as a reminder of your work here."

Snakes and babies

Family practitioner James A. Kliewer, MD, of King's Daughters Clinic in Temple, went to the Balkans after seeing hordes of Albanians flee Kosovo and the crowded refugee camps on the evening news broadcasts. "I felt if we didn't respond, if we couldn't offer assistance, there could be worse disasters," he said.

Dr Kliewer volunteered after receiving an e-mail from his daughter, a student at Southwestern University in Georgetown, about the efforts of the school's faculty and alumnus Red McCombs to organize a medical mission through IMC. In early May, he traveled to Skopje, Macedonia, where he was assigned to live and work for the next month in nearby refugee camps.

Dr Kliewer had many things to get used to, not the least of which was the weather. "One morning, it was still 32 degrees in the clinic at 9 am. About a week later, it was over 100 degrees in the tents," he said.

Gasoline-driven generators supplied the IMC physicians with intermittent power, but the refugees had no power in their tents and precious little else, except what they had managed to carry during their escape. Ration cards supplied one blanket per tent and a tin of meat, milk, bread, cheese, and one vegetable per person, per day.

Women who delivered babies at the camp placed their infants in cardboard boxes suspended from tent poles by ropes to keep the newborns safe from the snakes that roamed unmolested through the tent cities. "We were not allowed to kill the snakes because they ate the rats carrying disease," Dr Kliewer said.

During his tour, Dr Kliewer saw many depressed patients and described others as "beyond pain, having suffered more grief over a period of days than most individuals experience in a lifetime."

Improving lives

Orthopedist Brian Parsley, MD, a surgeon at St Joseph's Hospital in Houston, had been to Hermano Pedro Hospital before. But this year, he served as director of the medical mission to Guatemala and led a large group of volunteers from St Joseph's, along with a team of physicians from across the country. Fellow orthopedic surgeon Brad Urquhart, MD, went along to treat pediatric patients.

"One of the most rewarding experiences of this mission was being able to help a young teenager who had to walk

Photo courtesy of Faith in Practice

Brian Parsley, MD, visits a Guatemalan child after performing surgery to release muscle contractures caused by cerebral palsy.

on her hands because of the crippling effects of polio," Dr Parsley said. "After releasing multiple contractures with surgery, we provided her with custom braces and crutches so she could walk upright for the first time in her life."

This trip, however, was much different from previous missions because the surgeons were able to see former patients who returned for additional surgery. "It was rewarding to see the confidence they had gained and to feel their trust in us," he said.

Much of the additional surgery was made possible by equipment donated to the mission by St Joseph's. "One valuable addition to the mission was a large-capacity steam sterilizer that allowed us to sterilize whole sets of instruments rather than small packets, one at a time," Dr Parsley said.

Members of the mission also nurtured ongoing relationships with the local medical community and made plans to work with them next year in other facilities in Antigua that could facilitate more complicated procedures.

Dr Urquhart treated one child with a severely deformed right hand and forearm. After performing an initial procedure in Antigua, he arranged for the child to go to Houston's Shriners Hospital for a series of operations to restore normal function to the arm and hand. Shriners picked up the tab for the child's transportation and care.

"We can offer an improved quality of life . . . by correcting clubfeet so little children can walk or by providing people stable joints so they can stand again and go back to their villages to work in the fields," Dr Parsley said. "The Central American countries do not tolerate people with deformities, because if they can't work, there's often no one to take up the slack."

Like most medical missions, the volunteers pay their own expenses. Instruments, supplies, drugs, and equipment come from in-kind and cash donations from individuals, churches, hospitals, medical equipment manufacturers, and pharmaceutical firms.

Eye-opening experience

M. Bowes Hamill, MD, associate professor of ophthalmology at Baylor College of Medicine Cullen Eye Institute in Houston and president of the Texas Ophthalmological Association, has volunteered for eight ORBIS missions and plans to continue until he "gets too old to go or they quit asking me."

ORBIS, a private, nonprofit organization, is a teaching program that allows physicians in foreign countries to observe and learn new techniques and procedures from teams of three US surgeons who spend a week with each mission.

Dr Hamill says his participation with ORBIS has changed his life. "Anytime you do anything like this, you cannot help but be changed by the experience," he said. "Yes, I have the opportunity to see conditions I don't usually see in Houston, but when you operate in a foreign country, you also remember how life-changing cataract surgery is for the 65-year-old man who can't see his grandchildren or for the child who will have an opportunity to enjoy a higher quality of life."

He also values the friends he has made through the missions. "I am still in contact with physicians I met in Sarajevo 10 years ago," Dr Hamill said, adding that he has lost several friends in civil wars and other foreign strife. "These are contacts that really stick. They're at your elbow in the OR, you may go out to dinner, or they may invite you into their homes. That's the value of ORBIS — for both teacher and students."

> "Medicine is my gift, and I'm being allowed to do what I'm supposed to be doing."

Personal fulfillment

For Dr Parsley, being a part of Faith in Practice offers him "the opportunity to fulfill part of my own personal mission. The Lord gives us all gifts, and how we use them makes a difference. Medicine is my gift, and I'm being allowed to do what I'm supposed to be doing."

His journey to Macedonia brought Dr Kliewer's life into sharper focus and he would go back "in a heartbeat. The Kosovars needed to know someone cared . . . and cared enough to offer whatever help we could, from treating basic medical problems to simply listening to whatever they wanted to share."

And for Dr Hamill, his missions with ORBIS have offered him "the opportunity to go to extraordinarily interesting places and to teach in one of the best teaching facilities I've seen. But it also affirms why you are in medicine. By and large, most people are in medicine because they feel it is a noble enterprise. But any time you have the opportunity to make a difference, to get out and go beyond your usual practice, you will find a tremendous affirmation of who you are and why you went into medicine in the first place . . . because it has value and it has meaning . . . in our society and in the world." ★

Alice Adams is an Austin freelance writer.

"We're going to Honduras."

An Austin physician finds renewed purpose in the Third World

Editor's Note: In August, Austin surgeon Bruce McDonald, MD, his wife, and daughter joined a group of physicians, nurses, and other health care professionals from Austin and Round Rock on a weeklong medical mission to Honduras. The trip changed their lives and those of the Hondurans who desperately needed medical care. The following is Part 1 of Dr McDonald's account of that trip. Part 2 will appear in the December issue of *Texas Medicine*.

Monday, June 28
The call

It was after 9 pm when I finally got home that night. Monday after a vacation, and I was exhausted. I can remember when medicine was simpler. We would operate until late at night and the paperwork was tolerable. Now it seems we spend as much or more time on administration as we do in the OR. I'll take long nights of surgery over long nights of paperwork any day.

"You need to call Dr Rutledge right away," my wife, Pam, said as I walked through the door.

Dr (Elizabeth) Rutledge is a urologist in Round Rock. I wondered why she called. Pam said it was something about a medical trip. I dialed her number. I didn't know the call would change my life.

"We are desperate for a general surgeon," she pleaded with me. "I've called everyone I know and you are my last hope."

Well, okay. I was feeling a little like the high school wallflower who gets a last-minute invitation to the dance after everyone else declines. I inquired as to the nature of her desperation. "We are going to Honduras on a medical mission."

I didn't hesitate. "Fine, I'm in."

"It's in 6 weeks."

"No problem."

No problem? My partners were going to kill me. I had just returned from a weeklong vacation during the busiest season of the year.

"We want you to take Shelby, too," Dr Rutledge said.

I told her I was sure my daughter would love to go. I also volunteered my wife to serve as a recovery room nurse. Dr Rutledge was elated.

"You will be expected to pick up all costs of travel, lodging, and food. And you will have to provide your own instruments and most of your own supplies," she said.

"No problem." Just 10 minutes earlier, I had been exhausted after a long day of paperwork. Now I was pumped.

Dr Rutledge explained that Dr Jack Jacobson ("Dr J") had been on a previous medical mission and was organizing this one with the help of Medico, a nonprofit organization that sends medical missions to Third World countries. They already had commitments from a gynecologist and an orthopedist and were working on an anesthesiologist. Some of the OR personnel were going along.

I asked what kind of surgery I would be doing and was told there were lots of hernias, gallbladders, and thyroids. I hung up and pulled out my address book. I made a call to Jeffrey McKeever of Atrium (a medical supply company). He had been in my office just 2 weeks ago, urging me to use his new hernia mesh system. I had used it and was impressed. Now I would be able to give it a real test. Yes, he would supply mesh for the trip. A call to Eileen Gillespie of Ethicon (also a medical supply company) produced the same results. Ethicon would provide the suture. I dug through a box of old *National Geographic* maps and found a map of Central America. There it was, sandwiched between Nicaragua and Belize.

Honduras. I took a deep breath. Another adventure. This was going to be interesting.

Friday, August 6
The adventure begins

Our group of 21 Medico volunteers met at the Austin airport at 9 am. Representatives from Medico and the International Red Cross (we were part of the Honduran Red Cross Disaster Relief Team) were there to see us off.

The team consisted of five surgeons (urology, orthopedics, gynecology, and general), two operating room technicians, three nurses, an anesthesiologist, a nurse anesthetist, and various other personnel, including seven teenagers.

The plane jumped from Austin to Dallas to Miami to San Pedro Sula. Not exactly the most direct route, but because of late scheduling and the number of travelers in our group, we had to take what was available. After a long day, we arrived in San Pedro Sula at 8 pm. We loaded our supplies and ourselves into the rental bus and headed for the Gran Sula Hotel, a very nice Americanized Best Western. It was on the central square in San Pedro and there was a beautiful 18th century church outside our window.

We were all looking forward to our first full day in Honduras.

By Bruce McDonald, MD

Saturday, August 7
Welcome to Honduras

Not a good start. Dr Samora, our local liaison, was in Miami on vacation. The hospital employees were on strike.

Medically speaking, our hands were tied, so we decided to investigate our options for sight-seeing. We could go to the Mayan ruins or to the beach. The vote (heavily weighted by the kids) was for the beach. Since we had rented a bus and driver for the entire week, we figured the trip would be no problem. The driver figured differently and made a relatively feeble attempt to charge us $25 per person for a special "tour." Dr J kindly explained that we had already rented the bus once and did not intend to pay twice. Off to the beach.

Most of the students had never been to a Third World country before. The poverty and meager lifestyle was a real eye-opener for them. But the Honduran countryside was lush and green. There were mountains rising to the south. Coconut and pineapple groves as far as we could see. Just as we had begun to relax and enjoy the beauty, we were jolted back to reality by a horrendous accident. We found out what happens to a compact car when a truck tries to pass it by going over the top of it. Simple division actually: truck goes over car once with nothing left over.

It was the first of many such juxtapositions of beauty and atrocity that we would encounter. Take the beach, for example. Postcard material. Caribbean white sand and turquoise water. We enjoyed a swim for about a half-hour until we learned the water was contaminated with raw sewage. No more swimming for this group. Most of the kids managed to eat lunch without getting sick. We returned to the Gran Sula and went out for an Italian dinner. On the way back to the hotel, we were escorted by a police officer armed with a machine gun.

Tomorrow, we would go to the hospital, and anticipation was building.

Sunday, August 8
Reality hits hard

8 am. The team was ready for action. We loaded the supplies and headed for the hospital. I was no stranger to Third World medical facilities. I expected the worst, but nothing could have prepared me for the shock of seeing Hospital Leonardo Martinez for the first time. Hurricane Mitch, along with the ravages of poverty, had taken its toll. The hospital was a series of one-story buildings made of masonry and corrugated metal roofs. A high steel gate enclosed the parking lot. The main hospital building, the operating room building, and the clinic buildings were functional. The rest of the buildings were stacked high with antiquated equipment and, in many cases, lacked windows and doors.

The courtyard was a miasma of rotting garbage, bottles, cans, paper, cardboard (of course), and discarded equipment, including six iron lungs from the March of Dimes. Among the debris were patients — mostly women in labor — with nowhere else to go while they awaited treatment.

The operative suite instrumentation was, at best, circa 1950. The building itself was dilapidated with faulty, jury-rigged plumbing and wiring. It was hot. The air conditioner was running but it had been repaired beyond its useful life span.

We had just begun to unload our supplies when we encountered hurricane gale opposition in the form of the OR supervisor. She was literally overwhelmed by our presence. Previous medical missions had merely come down and handed out vitamins. We were actually going to do surgery and, judging by the 25 crates of supplies and instruments, we meant business.

We convened in the break area and tried to explain what we needed in the way of support. Like most OR supervisors I know, she preempted the conversation by laying down the law to us. We were not to show up in scrubs but to wear street clothes in and change at the hospital. We were to wear lab coats whenever we left the OR, and hats and fresh shoe covers (*botas*) at all times. She informed us that our requests would be handled "*mañana*." Without our local liaison, Dr Samora, we had very little leverage. Without a strategy, we were powerless. We hatched a plan.

I can remember when medicine was simpler. We would operate until late at night and the paperwork was tolerable. Now it seems we spend as much or more time on administration as we do in the OR. I'll take long nights of surgery over long nights of paperwork any day.

Bruce McDonald, MD, and his surgical team perform hernia surgery, Honduran style.

Photo courtesy of Bruce McDonald, MD

Patients fill an open ward at Hospital Leonardo Martinez in San Pedro Sula, Honduras.

I was no stranger to Third World medical facilities. I expected the worst, but nothing could have prepared me for the shock of seeing Hospital Leonardo Martinez for the first time. Hurricane Mitch, along with the ravages of poverty, had taken its toll.

We gave the OR supervisor the official title of "Nurse Ratchett." Dr Michelle Irwin volunteered for the job of killing her with kindness, and finally, after much negotiating, we were allowed to make the OR usable for surgery.

Dr Ed Lewis and Nicky Mutt (a nurse anesthetist) rehabilitated the anesthesia machines and got one out of four to work. The cautery machines were hopeless. Nurse Marilyn Kasper set up and organized the supply room, and the students, technicians, and recovery personnel prepared sterile surgical packs. The surgeons went off to the clinic to see patients.

There were patients at the clinic, but not as many as we expected. The word had not gone out that we were bringing an orthopedic surgeon or gynecologist. Michelle and David (orthopedic surgeon David Gillory, MD) were, of course, disappointed, but we all dug in and saw the patients who had come. We saw many very large prostates and hernias, gallstones, and thyroid masses.

One patient, Kristina, was 61 and had suffered with a thyroid tumor for many years. The goiter made it very hard for her to breathe and swallow, and she had not been able to eat solid food for the last 2 years, but she traveled for 2 days by foot, mule, and finally, on a sugar cane truck to get to the clinic. She was staying with her daughter and waiting for surgery.

Another patient, Elizabeth, had a third breast, which became very painful when she lactated. She cleaned houses and by the end of her workday, she was in misery. We scheduled her for removal of the breast. The surgery was to be done under local anesthesia and would take only 15 minutes — a small matter to us; it meant a world of difference to Elizabeth.

Antonio had endured a right inguinal hernia for several years before he came to see us. He worked as a mechanic, and the hernia had gotten large enough to prevent him from doing his best work. Because unemployment is high in Honduras, he had not been able to find much work after the hurricane destroyed his place of business. Repairing his hernia would give him a shot at employment and restore his ability to support his wife and three children.

Manuel, 63, came in with a bladder catheter and hernias. *"Abajo los pantalónes,"* I told him. His pants dropped to the floor and revealed two hernias as large as cantaloupes. Manuel spent his life working on a sugar plantation until he cut the tendons in his right wrist with a razor-sharp machete. We put him on the surgery schedule to remove the prostate and repair the hernias.

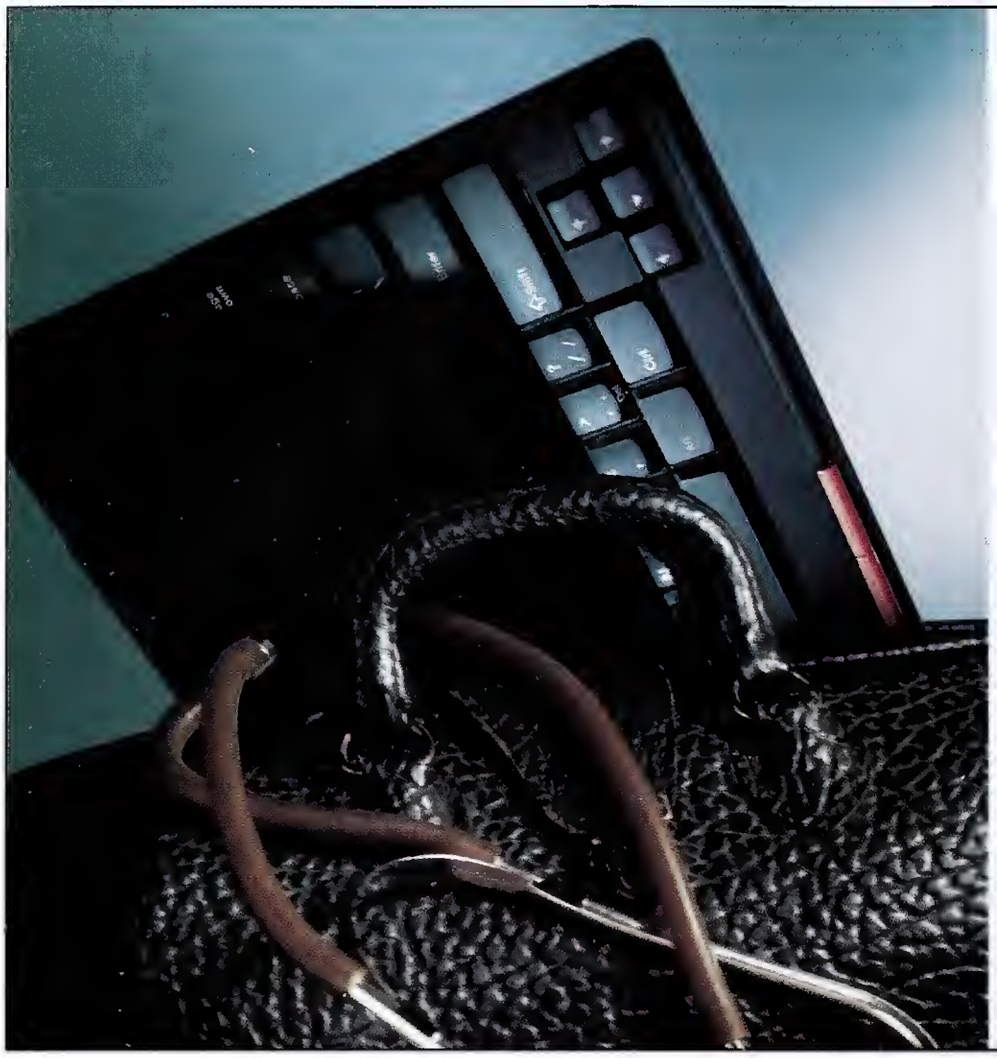
The next patient was a 3½-year-old boy born with bilateral hernias. I told his mother we would operate on her son in the morning and that everything would be *"muy facil."* She hugged me, and tears of joy ran down her cheeks.

I saw 20 patients that day and booked most of them for surgery during the week. Nurse Norma Reyes took over the scheduling and organization of the ORs. Norma, who was to be our interpreter, had some difficulty with the Honduran dialect, so we all did our best.

After we finished seeing patients, we headed back to the OR to help make up sterile packs. Michelle tried to get Nurse Ratchett to run the sterilizer so the packs would be ready in the morning — once again, we were instructed to wait until *mañana*. There was no running water, and running water also was a *"mañana"* item.

The troops returned to the Gran Sula late afternoon. We realized we were up against the Honduran system of *"mañana"* and we would have to deal with it. Our emotions ran the gamut, from wonder at the pathology we had seen, to excitement that we would finally get to do surgery, to frustration at the problems we would not be able to overcome, to the sheer terror of tackling some of the most difficult of surgeries under the most extreme Third World conditions. We were all emotionally and physically exhausted. We went to our rooms but most of us didn't sleep.

Coming in December: Dr McDonald and the other members of the medical team overcome primitive conditions — including a memorable encounter with a three-legged cat — to treat dozens of patients. In the process, they rediscover the joy of practicing medicine.



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New waiting game rules

Who should say how, or if, our organ allocation process should change?

Life's inequities can be palatable if a person feels every effort is being made to correct the injustice. Most transplant patients understand the fairness of a waiting list for organs. Any hint, however, of game-playing or an economically driven allocation practice can taint the public's perception of an already bewildering process for organ allocation in this country. ➤➤

By Monica Maldonado, Associate editor

Tell a Texan, for instance, that the state exports more organs than it imports, and eyebrows rise significantly. So when State Sen Mario Gallegos (D-Houston) introduced Senate Bill 862 during the past session of the legislature, some people cheered its "Texas first" mantra for organs donated in the state. But the organ allocation system is divided into many factions, and enough noise was made to shelve the idea. Retooled, the bill created a 13-member task force and charged it to "develop and implement an optimum organ allocation policy for Texas" by October 1, 2000.

With representatives from every faction and their respective agendas, the task force has just begun its struggle to understand the seemingly illogical organ allocation system. Even if it succeeds, the US Department of Health and Human Services (HHS) may impose its own controversial solution nationwide.

"As a patient, I could live with an allocation process that in my heart I know is fair to the state," said former Texas Medical Association President Phil H. Berry, Jr, MD, a liver transplant recipient and chair of the SB 862 task force. "But as a physician, if a decision about a transplant were made against one of my patients, I'd get very defensive. So I think the biggest point of contention in this task force will be about balancing that with what's best for the entire patient population."

Ideally, the allocation system should give organs to patients who need them the most. But the issue is complicated because the sickest patients often have the worst outcomes and are the most expensive to transplant. The median price of a liver transplant is about $150,000, and kidney transplants cost between $20,000 and $50,000. To perform those transplants, the hospital must have donated organs, expert surgeons, and the agreement of a health care plan to pay.

The business side of transplantation definitely exists. The possibility that one system could be more successful, or more profitable, than another raises issues about the value of competition and the importance of alternatives for critically ill patients.

How the system works now

The alliance among organ procurement organizations (OPOs), transplant centers, and hospitals is key, and each feeds off the other. The state's current organ allocation network was built over time, and some people feel it doesn't make sense anymore.

The network consists of three OPO regions centered in Houston, San Antonio, and Dallas, in which organs are procured and distributed. As an example, consider a kidney transplant. Under the current system, the organ is allocated first to transplant centers within the OPO region in which it was procured. (Each OPO has its own list that is also a part of a national waiting list. For the most part, the first criterion is the location where the organ was procured; from that point, the criteria become clinical.) If the organ does not match a patient in that region, it's offered to Region 4 (1 of 11 national regions), which includes Texas and Oklahoma, and then to the entire country. The system is slightly different for livers: a donated liver is first offered for match to Status 1 patients in all of Texas, then to the OPO region in which it was procured.

But this is the scenario causing all the problems: suppose a liver becomes available in Dallas. If the OPO fails to match it with a Status 1 patient in the state, it tries next with Status 2A, Status 2B, and Status 3 in its region. Thus, a Status 3 patient in Dallas might receive the organ while a Status 2A patient in Fort Worth, which is in a separate region, has to wait for the next liver.

But what if the Dallas region cannot match the organ to a patient? It is then offered to the national Region 4, which includes all of Texas and Oklahoma. What doesn't make sense to some people is that Status 2A patients in nearby Fort Worth are given the same shot at the organ as Status 2A patients in, say, Oklahoma City.

"You can't justify that situation," argues Goran Klintmalm, MD, chief of transplantation at Baylor University Medical Center in Dallas. "My point is that we are just the stewards of the organs, and the organs have to go where the patients are."

This summer, Dr Klintmalm opened a new kidney transplant center in Tarrant County at the Baylor Medical Center in Grapevine to allow his Dallas patients to

The task force

Members of the Senate Bill 862 Task Force, appointed by Texas Commissioner of Health William R. Archer, MD, are:

Phil H. Berry, Jr, MD, Chair
Southwest Transplant Foundation
Dallas

James Cutler
Executive Director
Southwest Transplant Alliance
Dallas

Fred Geiger, MS
Regional Administrator
United Network for Organ Sharing
Richmond, Va

Patrick Giordano
Chief Executive Officer
Texas Organ Sharing Alliance
San Antonio

Glenn Halff, MD
Director
Organ Transplant Division
The University of Texas Health Science Center at San Antonio

Kristene Gugliuzza, MD
The University of Texas Medical Branch at Galveston

Ernest Hodge, MD
Surgical Director
Renal Transplant Program
North Austin Medical Center
Austin

Sam Holtzman
President
LifeGift Organ Donation Center
Houston

Barry Kahan, MD, PhD
The University of Texas-Houston Health Science Center

Marlon Levy, MD
Transplant Department
Baylor University Medical Center
Dallas

Lawrence Schakde, PhD
Patient Representative
Dean, School of Business
The University of Texas at Arlington

Patrick Wood, MD
Texas Liver Center
Houston

Manuel Zapata
Patient Representative
End-Stage Renal Disease Network, Region 14
Austin

join the shorter waiting list for Fort Worth as well. Before this, Dr Klintmalm says, all of the kidneys procured in the Fort Worth region, served by the LifeGift Organ Donation Center, were being sent to Houston, which is part of LifeGift's area. "This is just to try to get some fairness in an unfair system," he said. Since opening, Dr Klintmalm reports, Baylor's Grapevine kidney transplant center has received most of the kidneys available in LifeGift's area.

The move gives Dr Klintmalm's patients an advantage if they have been on the waiting list in Dallas for a long time. While a patient can be on the national list as both a Dallas and a Fort Worth patient, he or she can only have one waiting time. So if Dr Klintmalm's patient has been waiting for 200 days in Dallas, he or she becomes a Fort Worth patient who has been waiting for 200 days, but forfeits his or her days on the Dallas waiting list. Since each OPO determines a kidney-patient match a little differently, this can be a big plus in Fort Worth, where blood matching and waiting time counts more than tissue typing, the way patients are prioritized in Dallas.

"My point is that we are just the stewards of the organs, and the organs have to go where the patients are."

"Because there are fewer people on the overall list in Tarrant County and because we do a better job of recovering kidneys and we have a greater supply, Dr Klintmalm opens his patients to a new supply of organs," said Sam Holtzman, president of LifeGift Organ Donation Center.

"From the patient's perspective, he or she could do the same thing by being listed in Louisiana and get the same effect," said Mr Holtzman, who is on the SB 862 task force. "However, in that situation, Dr Klintmalm and Baylor would lose the patient and the economic advantage of having that patient." That, he says, is the essence of this whole struggle.

TMA Advantage: Live & Then Give lives on

Although the original Live & Then Give organ donor awareness campaign was completed more than a year ago, the Texas Medical Association, the TMA Alliance, and the Texas Transplantation Society continue to carry out activities related to the project, thanks to continued funding by the TMA Foundation. These activities include the following:

- **Live & Then Give has provided materials to several state medical associations interested in developing their own organ donor awareness campaigns and has consulted with the American Medical Association on its efforts to launch a national campaign based on the Texas program. Live & Then Give also joined AMA in seeking a federal grant to allow former TMA President Phil H. Berry, Jr, MD, and TMA staff members to help train other state medical societies in how to conduct their own campaigns.**
- **Between 75 and 130 requests are received each month for donor cards through a toll-free hotline number, (800) 560-7812. Several physicians' offices, hospitals, clinics, and social work centers also have used the hotline to request donor cards to distribute to patients or clients.**
- **In cooperation with the state's organ procurement organizations, Live & Then Give printed an additional 2 million donor cards with stickers to be distributed through driver's license offices. For the first time, these cards also were printed in Spanish, and some 400,000 Spanish cards have been distributed.**
- **About 75 people attended a Live & Then Give continuing medical education (CME) course that met the Texas State Board of Medical Examiners requirement for 1 hour of ethics CME at the Texas Transplantation Society annual meeting in Galveston in June. The session was videotaped for a home study course that is now in production. More information on the video's availability will be in future issues of *Texas Medicine*.**

Is competition good for the patient?

Senator Gallegos' original "Texas first" proposal sent a shock wave through the transplant community. Many feared it would unfairly put the Dallas-based Southwest Transplant Alliance network at an advantage. Because it has the longest waiting list, statistically most of the organs procured in the state would be sent to that region. In April, Southwest reported it had 1,219 patients on the waiting lists for kidneys and livers, Houston's LifeGift reported 778, and the Texas Organ Sharing Alliance in San Antonio reported 786. The result might be that many smaller transplant centers in the state would have to close down.

"Transplant centers are under the gun," said Patrick Giordano, Texas Organ Sharing Alliance chief executive officer and a member of the SB 862 task force. The centers' success depends on a steady flow of organs. The more organs a center receives, the more transplants it can do and, consequently, outcomes will improve. That's why transplant centers align themselves with organ procurement organizations that can offer the most organs. "It's also more cost-effective to do a high volume at transplant centers," he added. "Having access to organs

so that you can have access to care for your patients is what drives everything."

This leads to a problem for organ procurement organizations, which are also under pressure to perform. Mr Giordano says the certification process used by the Health Care Financing Administration unfairly measures performance on donors per million. A few years ago, his Texas Organ Sharing Alliance was in danger of being dissolved — and having its region taken over by neighboring OPOs — because it was struggling to meet this criterion. The San Antonio-based OPO includes South Texas and much of the border region, so high birthrates skew its performance, Mr Giordano says. "Even though my donations have improved over the last 4 years some 39% cumulatively — better than any other OPO in Texas — I could still go out of business if the birthrates keep going up. That can impact access to care and transplant center viability."

"Is the purpose of an organ allocation process to help patients or to guarantee the survival of certain transplant centers?" asked James Cutler, executive director of the Southwest Transplant Alliance and also a task force member. "And are we talking about an allocation or access issue?"

The difference between the current system and one with a broader list, he says, is not where, but how, allocation lines are drawn. "You've got to break that paradigm. It's the difference between a line drawn by medical and scientific logistics versus what the patient perceives as an arbitrary geographic line."

Recreating the system

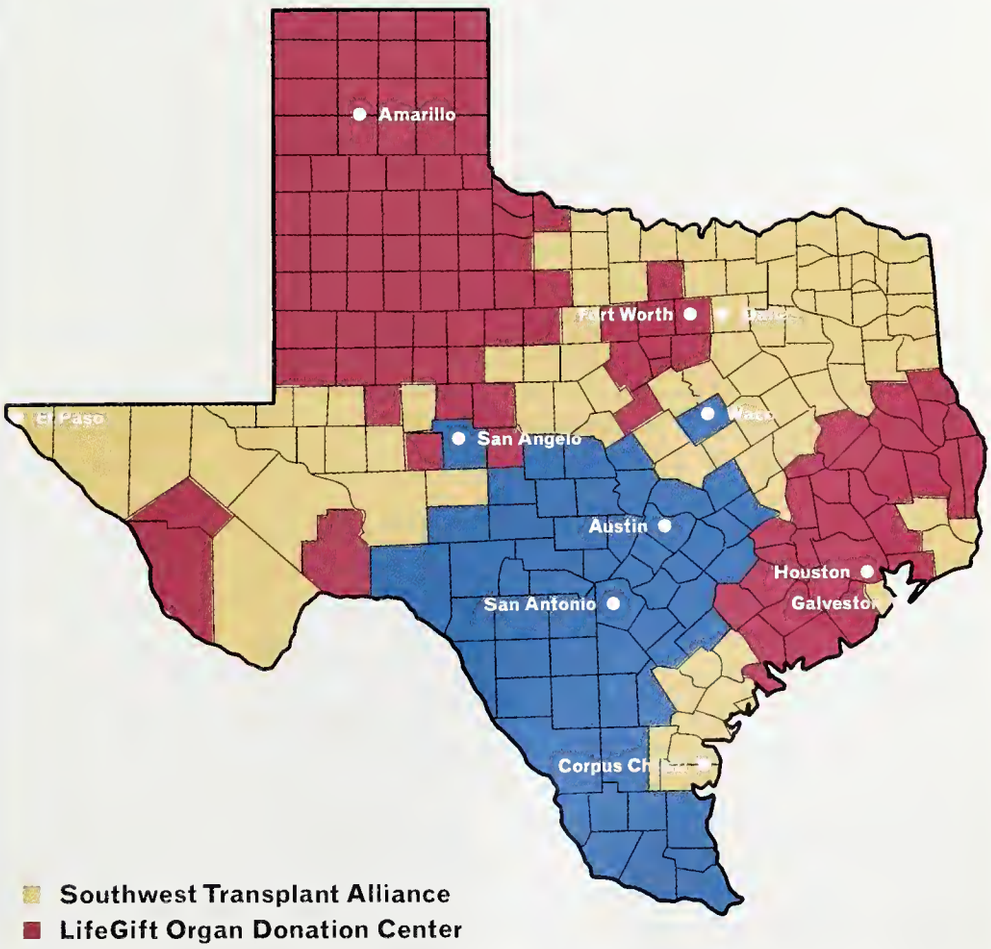
Culling transplant recipients from a broader geographic list is one of the principles of a new system, known as the Final Rule, proposed by HHS. Controversy over this issue and other provisions of the proposal caused Congress to suspend its implementation until October 21, 1999. At press time, if and how the Final Rule would be implemented was not known. In the meantime, Congress asked a third party, the Institute of Medicine (IOM), to review the current Organ Procurement and Transplantation Network policies, which are carried out by the United Network for Organ Sharing (UNOS), and the potential impact of the proposal.

The IOM report, issued this summer, is being used by both sides of the debate. The report focuses on liver transplantation because of the unique factors in such procedures.

HHS interprets the report as supporting its proposal, mostly because it agrees with the proposal that larger organ-sharing regions should be developed and that the department should take a more active role in overseeing the Organ Procurement and Transplantation Network. But UNOS contends the report disagrees with HHS reliance on what it says is misleading information — median waiting times. The report recommends that a more meaningful indicator would be status-specific rates of patients' pretransplantation mortality, which would indicate whether a patient would survive.

> "If our current system in Texas looks complicated, it's really because it's made up of a series of compromises trying to address all these areas."

Organ procurement organizations by county



Bob Spieldenner, a UNOS spokesman, says HHS has indicated it's going to make some changes to its proposal before it is implemented, "but we don't know what they'll be based on, and we haven't actually seen anything done." Depending on how the Final Rule is eventually interpreted, Mr Spieldenner says UNOS will have to develop a new policy. No deadline for this has been set.

In the meantime, Texas, along with about 10 other states, is racing to develop its own policy. Whether a state policy would supercede a national one is also up in the air. Linda Weigman, JD, counsel for the Texas Department of Health and an advisor to the task force, says that while the task force could not sue HHS over the allocation policy, one of the OPOs or transplant centers, or an alliance of them, could. In fact, Louisiana, which has its own allocation law, filed a suit last spring claiming that only an act of Congress, not a bureaucratic regulation, could override a state law. That suit is being held in abeyance until HHS determines what it will do with the Final Rule.

Weighing in on the debate, Robert W. Sloane, Jr, MD, Fort Worth, chair of TMA's Council on Legislation, says that ultimately the SB 862 task force must ensure that the allocation system is based on good science and good patient care. "These are questions that have been in the transplant community for decades. If our current system in Texas looks complicated, it's really because it's made up of a series of compromises trying to address all these areas," he said.

"We can't have the system being driven by transplant centers," said Mr Cutler of Southwest. "It has to be driven by patients." He says that in previous work with transplant patients as a clinician, he found it difficult to explain to patients awaiting an organ why they didn't get one that day. "Very few patients know why these lines exist. We have to remember that in coming up with an organ allocation system, we first have to decide what we're trying to achieve." ★

Monica Maldonado can be reached at (800) 880-1300, ext 1385, or (512) 370-1385: or by e-mail at monica_m@texmed.org.

Research roundup: A short list of research from around the state

THE UNIVERSITY OF TEXAS SOUTHWESTERN MEDICAL CENTER AT DALLAS — An enzyme deficiency is responsible for some cases of sudden infant death syndrome (SIDS), according to a study of 150 cases. Of that group, 2% had the deficiency. The findings could lead to postnatal testing for those at risk. The deficiency occurs during the breakdown of fatty acids from fat stored in the body. Ordinarily, the body would tap into these fats when its normal supply of energy is depleted. In the event of fasting, infants have to rely on the stored fat for energy. If the enzyme deficiency is present, fatty acids enter the liver but fail to generate energy or produce ketones, a vital energy source for the brain. In this case, SIDS occurs because of a lack of ketones. The researchers recommend avoiding any circumstances for fasting in infants.

THE UNIVERSITY OF TEXAS HEALTH SCIENCE CENTER IN SAN ANTONIO — The signal from the brain to stop eating may happen later in obese people than in lean people, according to research at the Research Imaging Center here. The experiments used functional magnetic resonance imaging to monitor the brain's reaction to stimuli. Ten obese and 10 lean middle-aged adults were fed a sugar solution as researchers monitored their brains. According to Jia-Hong Gao, PhD, an associate professor of radiology and one of the principal investigators, the brains of the heavier subjects responded more slowly and used less energy. Researchers plan to enlist diabetics in a repeat experiment.

UNIVERSITY OF NORTH TEXAS HEALTH SCIENCE CENTER — Brain activity regulates blood pressure, and during exercise, muscle activity modulates what the brain tells the heart to do. Researchers here want to determine how this plays out during exercise. The health science center received a $950,000 grant from the National Institutes of Health to determine how the brain resets the baroreflexes, the collection of sensory nerve endings specialized to monitor changes in blood pressure. Researchers also will examine how impulses from muscle reflexes reach the brain to adjust heart rate and blood pressure during exercise.

THE UNIVERSITY OF TEXAS-HOUSTON HEALTH SCIENCE CENTER — Despite following recommended guidelines for eliminating contamination, six cancer centers in the United States and three in Canada had dangerously high levels of residual toxic contamination from cancer chemotherapy drugs, researchers here found. They believe the presence of the cytotoxins, especially around supposedly safe biological safety cabinets, could lead to health problems in workers exposed to these chemicals. The study, led by Thomas H. Connor, PhD, took wipe samples from around the cabinets, the floor in front of the cabinets, and other areas of the workrooms, and in the ambulatory care areas. Seventy-five percent of the pharmacy areas and 65% of all the drug administration areas showed contamination. The researchers recommend that safety guidelines for those drugs be revised.

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Taking the last train

Ophthalmologists, optometrists strike compromise to ensure collaboration

FD&S

The showdown between ophthalmology and optometry over legislation to allow optometrists to treat glaucoma and perform laser surgery promised to be one of the nastiest turf battles of the 76th Texas Legislature. But thanks to the take-charge attitude of one Texas lawmaker and hard work by ophthalmologists, family physicians, and others, a compromise was reached that diffused the mounting tension between the two professions. It also promises a closer working relationship between two important members of the health care team. ➤➤

By Ken Ortolon, Associate editor

On April 29, then-Texas Ophthalmological Association President Jerry D. Hunsaker, MD, of Corpus Christi, wrote State Rep Kim Brimer (R-Arlington), informing him that the association formally endorsed the committee substitute for House Bill 1051. "We believe that, with the provision for mandatory ophthalmological involvement in the care of patients with glaucoma, that the best safeguards for these vulnerable patients have been put into place," Dr Hunsaker wrote.

The next day, the House approved HB 1051 on its Local and Uncontested Calendar — a stunning development, considering that ophthalmology and all of medicine would have been prepared for war if the original version of HB 1051 had ever reached the House floor.

Fruitless negotiations

When the legislature convened in January, a compromise between physicians and optometrists on any scope-of-practice issue was not expected. The ophthalmological association and the Texas Optometric Association had been locked in negotiations virtually since the end of the 1997 legislative session. In that session, a bill identical to the original version of HB 1051 cleared the House Public Health Committee but never made it to the House floor for debate. At the urging of the House leadership, ophthalmologists and optometrists began meeting in September 1997 in an attempt to prevent another bitter scope-of-practice battle in 1999.

The negotiations' goals were to compromise on scope-of-practice issues and identify areas of mutual interest where optometrists and ophthalmologists could cooperate. The negotiations ended after several months of earnest but fruitless efforts. Even an attempt to use a professional mediator yielded no results, says Jay Propes, executive director of the ophthalmological association. When the 1999 session convened, Representative Brimer filed the same bill that had been bitterly contested 2 years earlier.

Ophthalmologists say that bill would have been an unmitigated disaster for patients. It gave optometrists virtually unlimited ability to perform laser surgery and minor surgical procedures, to provide full treatment of glaucoma, and to administer and prescribe oral and parenteral drugs. Ophthalmologists felt this dangerously expanded optometrists' authority and could lead to serious consequences for patients.

"Many health problems in the body manifest themselves in the eye," Mr Propes said. "If you treat the eye without understanding how the body works, you could be covering up symptoms without fixing the underlying problem and, ultimately, cause long-term damage."

"Any time one of the families of medicine comes under this kind of attack, it's the duty of all of medicine to stick together and help out where we can."

As early as February, ophthalmologists and optometrists again were working with Representative Brimer to negotiate a settlement. The Texas Academy of Family Physicians (TAFP) weighed in on the issue in an effort to show that all physicians, not just eye specialists, were seriously concerned about the proposed radical expansion of optometrists' scope of practice.

"A lot of our family physicians were very concerned with giving nonphysicians the ability to prescribe Schedule II drugs and perform laser surgery," said Tom Banning, TAFP director of legislative affairs and communications. "Any time one of the families of medicine comes under this kind of attack, it's the duty of all of medicine to stick together and help out where we can."

However, TAFP members' efforts to enter the negotiations were cut short by Representative Brimer. When family physicians showed up for one negotiating session in his office, they were asked to leave.

"The sponsor of this bill did not even realize the family practice doctors would have a concern because this affected their patients," Mr Propes said. "He literally told them this bill had nothing to do with them."

The chair takes charge

With progress toward a compromise stalled and tempers flaring, it appeared the stage was set for the expected showdown on the House floor. But that's when State Rep Patricia Gray (D-Galveston), chair of the House Public Health Committee, stepped in. Representative Gray, who was serving her first term as committee chair, forced the parties back to the negotiating table.

"Chairwoman Gray took the issue over from the optometry lobby and said she was going to work with people she trusted from both professions to come up with a collaborative model," said Kim Ross, Texas Medical Association's vice president for public policy. "It went through many iterations and, as you might imagine, there was a lot of hair pulling and screaming."

Representative Gray says she jumped into the fight because the turf war had been going on too long. The two groups were still arguing over issues dating back to 1981 when the professions fought another ugly turf fight over optometrists' use of eye drops, she says.

The dispute "had legislators in a crossfire and, to me, there was a real public health issue related to glaucoma," she said. "There were lots of peripheral issues in that bill; my role was to strip those away and to identify the public health issue that we wanted to address."

Representative Gray says she looked at how collaboration between ophthalmologists and optometrists works in other states and incorporated what she saw as best practices into the committee substitute.

A bill eventually was crafted. As the session wound down, the proposal was presented to the executive committees of the ophthalmological and optomet-

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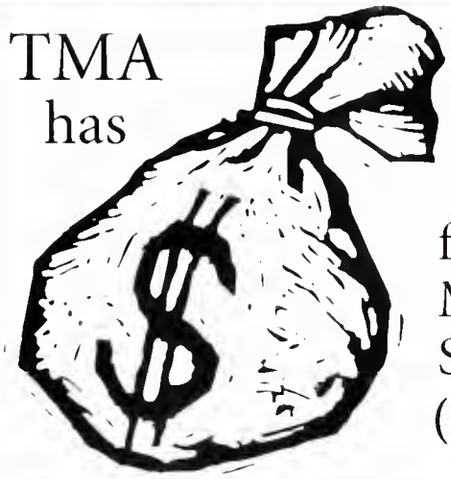

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ric associations. Though neither group was entirely happy, both signed off on the measure.

"We worked very hard to come up with a compromise with optometry, and we think we were successful in that regard," said Galveston ophthalmologist Bernard Milstein, MD, who was involved in the negotiations. "A reasonable bill was arrived at by intelligent people meeting with the legislature for the benefit of the people of Texas."

Mr Ross says Representative Brimer and Sen Frank Madla (D-San Antonio), the bill's Senate sponsor, also deserve credit for encouraging optometrists to compromise, reducing the scope of the conflict between the professions, and working with Representative Gray to develop a collaborative approach that ensures that ophthalmologists will be involved in all eye care.

Defining the solution

As approved, HB 1051 gives optometrists authority to initiate topical treatment for glaucoma but requires them to comanage cases with an ophthalmologist. The ophthalmologist is in charge of consultation parameters, and both professionals must approve the protocol for the comanagement. Optometrists also can prescribe certain oral medications, but only once and for only 3 to 10 days, depending on the drug prescribed.

While optometrists won these new roles in eye care, they did not get authority to perform laser or other types of surgery. In fact, the bill includes a definition of surgery proposed by ophthalmology and strictly prohibits optometrists from performing surgery. In addition, it establishes an Optometric Health Care Advisory Committee to set additional educational requirements for optometrists and to review possible expansions of the optometric formulary. The committee's decisions must be approved by both the Texas Optometry Board and the Texas State Board of Medical Examiners.

Finally, the bill forbids any new optometric scope-of-practice legislation until the 2005 legislative session, when all health professional licensing acts will be up for "sunset" review.

"This bill was a true accomplishment for ophthalmologists," Mr Banning said. "Not only did they get a 6-year moratorium on scope of practice, but they were able to get into statute for the first time a definition of surgery. That not only helps ophthalmologists, but it also helps the whole family of medicine and protects our patients."

Fostering cooperation

Mr Ross says the real significance of the legislation is that, even if accomplished through force of statute, it could bring true collaboration between ophthalmologists and optometrists, much like the collaborative relationships among physicians and nurses, physician assistants, dentists, and other health professionals.

"If anything, the relationship between optometrists and ophthalmologists in the field had been running the other way," Mr Ross said. "This was sort of like the last train to leave the station. This, legislatively, probably was our last chance to develop a collaborative model. Relations between the two professions just would have continued to hemorrhage."

Representative Gray also expressed hope the new law will foster a better working relationship between the professions that will improve quality of care for patients.

"We didn't go as far as Maryland, where an ophthalmologist is required to take charge before anything is done, but we didn't go to the other extreme, as some other states have done, and say optometrists can operate without any ophthalmology involvement," she said. "We focused on a comanagement plan. The trick will be to see if it will actually work."

If ophthalmologists and optometrists can work together, she said, "then we have the potential for saving sight in some people, and for ensuring that people are getting screened and getting seen faster, and, ultimately, that's for the public good." ★

Ken Ortolon can be reached at (800) 880-1300, ext 1392, or (512) 370-1392; or by e-mail at ken_o@texmed.org.

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Life-and-death decisions

A new advance directive law eliminates confusion for patients and physicians

Eighty percent of Americans die in medical institutions or under some other organized health care service, and 80% of those deaths are preceded by specific decisions to limit life-sustaining medical treatment. This means that many clinical physicians rely on end-of-life directives and laws to guide their decisions. Unfortunately, the old laws were murky with inconsistencies. But Texas' new advance directives and end-of-life care laws, which took effect in September, should provide more useful guidelines for physicians. ➤➤

By Robert L. Fine, MD, and Thomas Wm. Mayo, JD

Advance directives are legal documents that allow patients to plan for medical treatment decisions while they are of sound mind in case they are unable to make their wishes known in the future. In Texas, directives have included the Directive to Physicians, or "living will," passed by the legislature in 1977; the Durable Power of Attorney for Health Care, enacted in 1989; and the Out-of-Hospital Do-Not-Resuscitate (DNR) order, passed in 1995. These directives address three distinct situations:

- The Directive to Physicians permits a competent patient to express a preference for no treatment if he or she is diagnosed with a terminal condition and is no longer competent to make decisions about life-sustaining treatment.
- The Durable Power of Attorney for Health Care permits a competent patient to designate someone to make all medical decisions (not just those that concern life-sustaining treatment) on his or her behalf, if he or she loses decision-making capacity (even if the patient does not have a terminal condition).
- The Out-of-Hospital DNR order allows a patient with a terminal condition and a physician to execute an order instructing emergency medical personnel and other health care professionals to withhold cardiopulmonary resuscitation (CPR) in the event of cardiac or respiratory arrest.

Over the years, inconsistencies among the laws began to creep in, and our experience with the different directives made it increasingly apparent that certain areas needed improvement.

In 1997, the governor vetoed legislation that attempted to reconcile inconsistencies in the old laws. Soon after, a drafting committee that reflected the diversity of opinions about end-of-life care began to develop a new law that would eliminate the inconsistencies, enhance patient autonomy, and give physicians a more useful set of documents to guide end-of-life decision-making. The result was Senate Bill 1260, which was approved unanimously by the legislature this year and signed into law by the governor. The new law, the "Advance Directives Act," regulates all three types of advance directives.

Directive to Physicians and Family or Surrogate

The old Directive to Physicians, or living will, has been renamed the Directive to Physicians and Family or Surrogate. The title reminds all parties that the patient is expressing treatment wishes not only to his or her physician but also to his or her loved ones. Many physicians caring for dying patients have been asked by distraught family members to ignore a living will. The new directive says only the patient may revoke or change the living will.

Perhaps the most significant change is that the new law includes a process for dealing with disagreements between the physician and a patient's family or surrogate decision-maker, with or without a directive to physicians. In the past, a common disagreement involved a family requesting withdrawal of life-sustaining treatment from a patient who the physician believed should continue to be treated aggressively. The more common situation is a physician recommending that aggressive treatment be stopped because it is medically futile, yet the family insists the doctor "do everything."

The new law deals with both scenarios and follows a process used by some large tertiary-care hospital ethics committees for years and endorsed by the American Medical Association's Council on Ethical and Judicial Affairs. The new law codifies this process and provides a legal (and ethical) "safe harbor" for institutions. Philosophically, the new law supports the general concept of a right to refuse life-sustaining treatment but not an unlimited right to receive treatment the physician considers futile.

Following the procedures described in the statute will provide immunity from civil and criminal liability to physicians, other health care professionals, and institutional providers. These procedures include a mandatory ethics consultation; a reasonable attempt to transfer the patient to another physician or institution willing to honor the directive; and, in the case of medical futility disputes, continuation of life-sustaining procedures for at least 10 days after the ethics committee explains its conclusion in writing to the patient's surrogate.

An institution may elect not to follow this procedure and to forego the statute's immunity from civil and criminal liability. Then, the statute simply requires that life-sustaining treatment be continued until the institution has a reasonable opportunity to transfer the patient to another physician or facility willing to comply with the directive or the surrogate's treatment decision.

Another significant change deals with obtaining consent for withholding or withdrawing life-sustaining treatment for a patient who is incompetent, has a

Many physicians caring for dying patients have been asked by distraught family members to ignore a living will. The new directive says only the patient may revoke or change the living will.

Correction

"The Big Payback," August 1999 *Texas Medicine*, pp 52–54, listed the wrong telephone number to contact Tom Wright, JD, if you believe you could be a part of the class action lawsuit against Blue Cross and Blue Shield of Texas regarding assignment of benefits. The correct number is (713) 752-2332.

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terminal or irreversible condition, has not executed a directive, does not have a guardian, and has no available relatives who may, under the statute, consent to the discontinuation of aggressive care. Under prior law, such a decision had to be witnessed by another physician not involved in the patient's treatment. The new law continues that rule (with the modification that the second physician must concur in the treatment decision) and adds that concurrence also may be obtained from a physician-representative of the institutional ethics (or other medical) committee.

If a patient has executed an advance directive, either a terminal condition or an irreversible condition (plus incompetency) will activate it. But, in another important change to the law, the patient can request or refuse ongoing aggressive treatment. Another change is that the diagnosis of a terminal or irreversible condition may now be made by only one physician, rather than two.

To maximize clarity and consistency, the new law separates terminal and irreversible conditions into two distinct categories with separate definitions. Under the old law, the concept of irreversible condition was subsumed by the definition of terminal condition, and interpretations varied within the medical community.

In the new law, "terminal condition" refers to an incurable condition expected to cause the patient's death within 6 months even if life-sustaining treatment is given. In some ways, the notion of terminal illness is defined more narrowly now than under the old law. "Irreversible condition," however, is separately and broadly defined as a condition that is incurable, severely debilitating, and fatal without life-sustaining treatment. Thus, a patient with an irreversible condition might be kept alive for years. The persistent vegetative state is a good example; under the old law, many physicians and medical facilities resisted accepting living wills on vegetative patients, arguing that they did not have terminal conditions. This new category of irreversible illness encompasses a huge number of conditions, eg, advanced neurodegenerative diseases (multiple sclerosis, amy-

trophic lateral sclerosis, and dementia) and progressive organ failures of the heart, liver, kidney, and lung.

The law has a "savings clause" that allows a directive to physicians executed before September 1, 1999, to remain in effect and to be governed by the law that was in effect at the time the directive was executed (ie, the Natural Death Act), rather than the new law. Despite this provision, physicians should encourage their patients to execute directives again on new forms that comply with the new Advance Directives Act. This will eliminate any confusion about what the patient wants in the event of either a terminal condition or an irreversible condition and the loss of decision-making ability. Also, in the event of a treatment dispute involving an old directive, health care entities may follow the procedures described in the new law, just as many Texas health care institutions have been doing for years under the Natural Death Act.

Medical Power of Attorney

The Medical Power of Attorney, formerly known as the Durable Power of Attorney for Health Care, designates a surrogate decision-maker in the event a patient lacks the capacity to make and communicate his or her own decisions.

A disagreement between the physician and an agent holding a Medical Power of Attorney over a request for (or refusal of) care is as foreseeable as one involving a surrogate decision-maker and a patient's Directive to Physicians. Therefore, the new law specifies that the dispute-resolution process described in the Directive to Physicians law should be followed.

Under prior law, if the agent is the patient's spouse, the Durable Power of Attorney for Health Care would be automatically revoked if the couple divorced. Under the new law, the Medical Power of Attorney may provide that it is to remain in effect even if the patient and the agent divorce.

Out-of-Hospital DNR Order

The Advance Directives Act amends the former Out-of-Hospital Do-Not-Resuscitate (DNR) Act, which allowed a patient diagnosed with a terminal condition to execute an order instructing emergency medical personnel and other health care professionals to withhold CPR in the

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- **Medical Power of Attorney — This recently updated form also is available free from TMA.**

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TMA also sells the Out-of-Hospital Do-Not-Resuscitate form and bracelet for $2.16 each. Updated forms reflecting the change in law will not be available until February 2000. The form must first pass through the Texas Department of Health's Administrative Code process.

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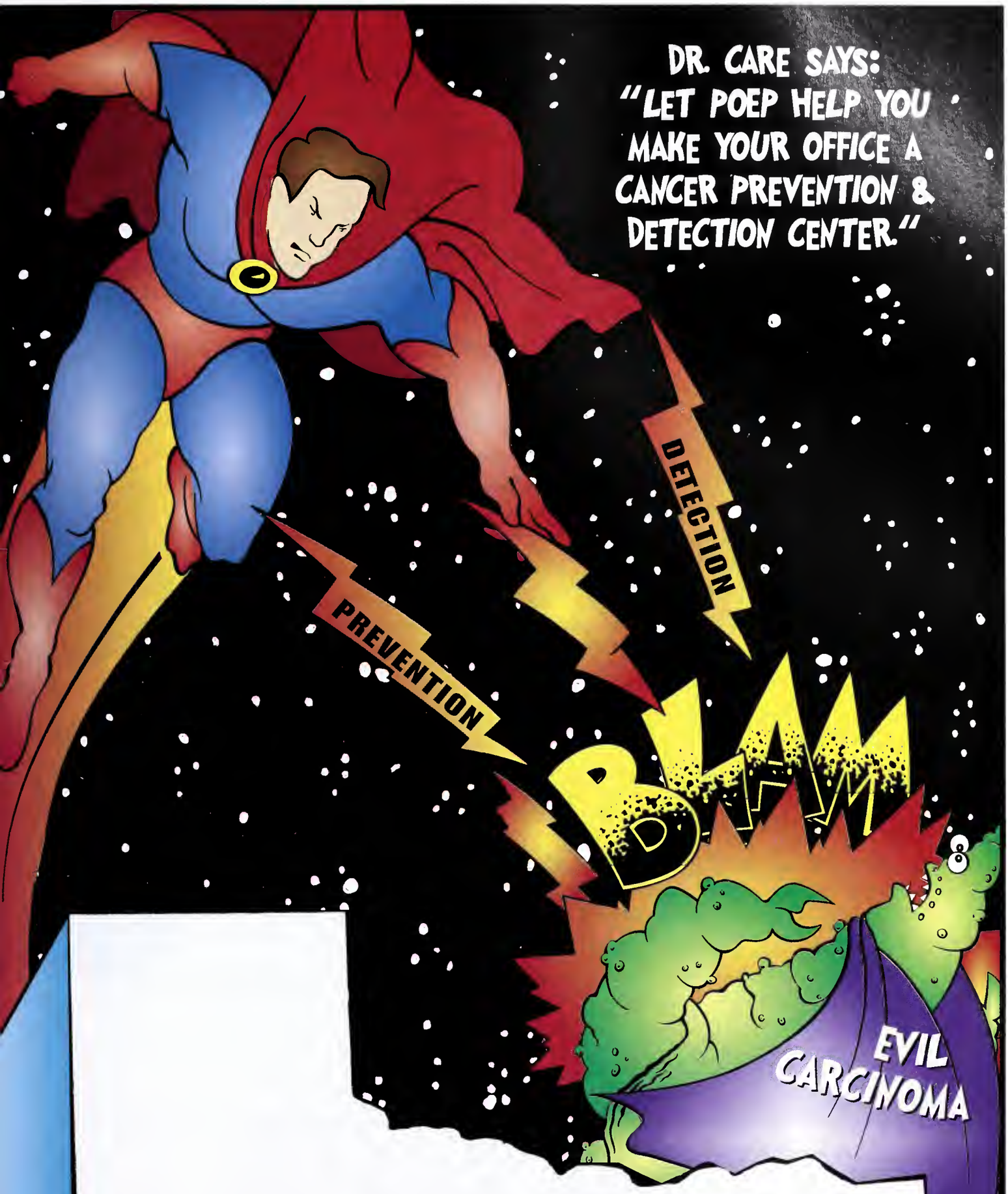
In the new law, the patient no longer needs to be diagnosed with a terminal condition to execute an out-of-hospital DNR order. Any competent adult may execute this advance directive, although it still requires the signature of an attending physician.

The previous law presented some confusion concerning patients who were brought to emergency rooms or to hospitals for outpatient procedures. Ordinarily, a physician would not write a DNR order in the emergency room, and because a patient was considered to be "in" the hospital, sometimes the emergency room staff would consider the out-of-hospital DNR invalid. So, in some cases, the patient would receive an unwanted resuscitative attempt. The new law avoids this by amending the definition of "out-of-hospital settings" to include hospital outpatient or emergency departments, as well as physicians' offices.

The new law permits resuscitation to be withheld when a person has an identification bracelet or an *original* out-of-hospital DNR order, as did the prior law, but it also permits resuscitation to be withheld on the basis of a photocopy of the out-of-hospital DNR order. The new law eliminates the legal immunity provisions that formerly applied when a responding health care professional knew a valid out-of-hospital DNR order existed and failed to effectuate it.

Because of the broad scope of the Advance Directives Act and its extensive revision of prior law, Texas physicians will be challenged to familiarize themselves with the many changes and to be prepared to counsel their patients. In addition, hospitals and other institutional health care providers need to work diligently with their medical staffs and provide needed support for their ethics committees, which have new duties and expanded responsibilities under the new law. ★

Robert L. Fine, MD, is director of the Office of Clinical Ethics at the Baylor Health Care System in Dallas. He was actively involved in writing the new law. Thomas Wm. Mayo, JD, is an associate professor at the Southern Methodist University School of Law in Dallas.



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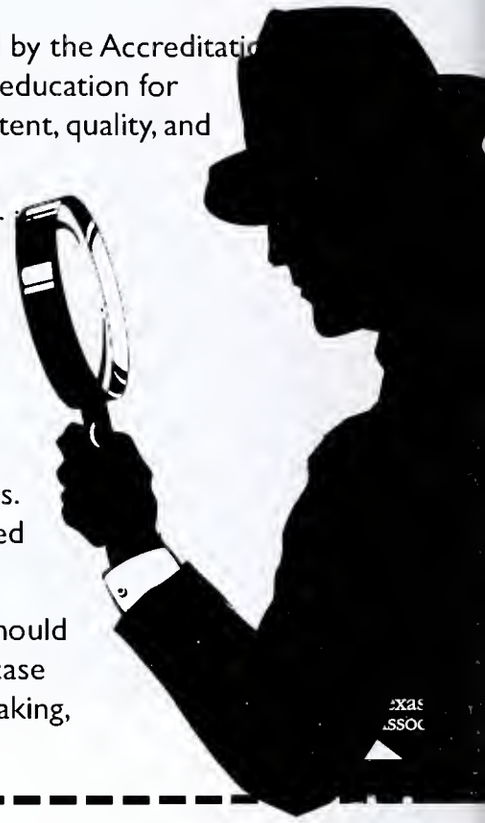

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A practice-based rural health fellowship: an innovative approach to support for rural care

WILLIAM J. CRUMP, MD
ROBIN B. BERSCH, MD

Efforts to support recruitment and retention of rural providers have sometimes included local postgraduate training. An innovative approach that includes training fellows entirely in a rural area with most of the costs supported locally was found to be cost-effective and to produce the expected positive effects. Training goals and objectives were accomplished in the areas of rural health and advanced maternity care, and the community gained an experienced provider as well as a new continuing education activity. This model may be applicable to many rural sites that have adequate clinical volume, experienced and motivated local faculty, and connection to a supportive regional medical center.

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INTRODUCTION

Many methods have been tried to support rural practice. Often called recruitment and retention efforts, these methods are based on the concept that the physician is the basis of health care. Although midlevel providers play an increasingly important role in rural health, ultimately a physician must supervise and coordinate the care they provide. The successful recruitment of a physician to a small community is a powerful economic driver, with one estimate of 18 jobs generated for each physician in practice (1). Most recent efforts have focused on retention, with the increasing understanding that this is more difficult than recruitment, and the appreciation of the negative effects of wasted resources and failed expectations when a new physician moves on after only a short stay.

Postgraduate training in rural areas is usually conceptualized as an important method of recruitment (2), but providing the extra health manpower also may be an important method of decreasing isolation and providing some respite for the overworked rural physician. Rural residency tracks where the last 2 years are spent largely in a rural area have been successful (3) but ideally are based in stable practices with at least 4 physicians (4). While this arrangement is preferred for residency training, by definition these communities are not among the most needy in terms of recruitment and retention.

Rural fellowship training for those who have completed a family practice residency is a more recent attempt to prepare individuals for the demands of rural practice (5). Often, these fellowships are focused around maternity care or other procedural training. The requirement for high clinical volume and the need to support the training program financially often dictate that much of the training time is actually spent in a metropolitan area, decreasing the experiential portion of the rural training. Our experience of a rural fellowship largely or entirely based in a rural area where providers are struggling to meet the needs of the population is presented for those considering innovations in recruiting and retaining rural providers.

BACKGROUND

Jasper, Tex, is a town deep in the Piney Woods of East Texas, home to a population of about 10,000. The nearest secondary care is available in Beaumont, about 80 miles away, and tertiary care, in Galveston or Houston, each about 160 miles away. Before 1992, Jasper had 6 active family physicians, 1 pediatrician, and 2 small hospitals, each with a daily census of about 20. Some of the perinatal care for county residents was provided in nearby counties, with approximately 200 deliveries per year in Jasper. In 1993, the town successfully recruited 2 recent graduates of a family practice/obstetrics fellowship; they were board certified and had received advanced training in complicated and operative maternity care. Associated with increasing reimbursement for Medicaid deliveries, the practice in 1994 had built the volume to 30 to 35 deliveries per month. At this point, one of the fellowship-trained family physicians decided to leave the practice for a teaching position. This precipitated a crisis of sorts, leaving 1 family physician and 1 midlevel provider to care for this high volume of mothers and babies, along with the considerable general medical population who had chosen these 2 family physicians for their care.

Working with The University of Texas Medical Branch at Galveston (UTMB), the practice provided regular

rotations of senior family practice residents doing rural electives, both as a learning opportunity for the residents and as a part-time provider for the practice to meet the needs during this manpower crisis. Still, the remaining family physician had to supervise all the care given, and some months had no resident on rotation, producing an increasingly untenable situation. In the fall of 1995, the family physician was successful in soliciting the temporary assistance of an obstetrician, a former faculty member in his fellowship, to move to Jasper to assist with the maternity care. This physician came to Jasper with his long-standing interest in teaching and, especially, in fellowship development intact. Also, UTMB had successfully recruited a physician (WJC) with a long-standing interest in rural health and fellowship training. He established a formal rural health program, with practice support as the key element. The rural residency rotations were set up with Jasper and several other sites, with supplemental funding from the Texas Higher Education Coordinating Board.

With curriculum having been in place for some time and the details of a proposed budget worked out (including medical liability coverage through the university trust), recruiting fellows remained the challenge. Graduation of the next residency class was 6 months away, and the Jasper physicians were considering how many fellows they needed and could afford. The program director at UTMB was considering appropriate ways to supervise a fellow remotely, including interactive videoconferencing and telemedicine. At this point, the director was contacted by a recently graduated family physician (RBB) who, through a mutual colleague, had heard of these plans. She was interested in a short minifellowship providing increased exposure to maternity care to facilitate the acquisition of privileges in the hospital associated with the practice she intended to join in the Northeast. A 3-month minifellowship, based entirely in Jasper, was designed and agreed upon by both sites, including funding by the Jasper practice. At the end of the second month in Jasper, all parties indicated interest in expanding the training to a full-year fellowship experience, and this became the pilot year for the newly designed Rural Family Practice/Maternity Care Fellowship.

Table 1. Rural health/maternity care fellowship.

Goals

- Increase knowledge and skills in recognition of illness patterns covering the entire spectrum of patient mix in rural areas
- Increase awareness of health care delivery systems and referral patterns and limitations in rural areas
- Increase knowledge and skills in delivery of multifaceted health care delivery to a patient mix from prenatal to geriatric, including the potential for all diagnostic categories
- Increase knowledge and skills in developing and presenting preventive medicine intervention in rural settings
- Increase knowledge and skills in development and delivery of patient and family medical and health education materials in rural settings
- Increase knowledge of developing delivery systems for managed care, and its parameters, in rural settings
- Develop and participate in educational presentations to medical students and residents on health care delivery issues and cases related to rural settings
- Develop skills in working with community leaders to solve health care problems in rural areas

METHODS

Curriculum

Based on a review of other rural fellowships, personal experience, and input from the departmental chair, goals (Table 1) were established. This process was important in many ways: once these goals were set, it became obvious that most if not all of them would require experiential learning, best received by living and practicing in a rural area. More specific goals for this portion were established (Table 2) on the basis of the director's past experience in training family practice residents in maternity care. Before the decision was made to situate the training entirely in the rural area, the director of the perinatal division at UTMB approved and "signed off" on these goals, with the understanding that with so many learners in the medical center, the desired volume of procedures would be problematic. A careful documentation system, based on a perinatal outcome instrument established previously by the director, provided procedural documentation (6,7).

Supervision

Originally, the plans were for a mix of 7 to 9 months in the rural area and 3 to 5 months spent in the medical center or at associated residency training sites. The time in the medical center would not only allow a fellow to concentrate on very high-risk obstetrics and address other educational needs, but also would provide the director an opportunity for firsthand observation of the fellow's skills and knowledge base. The supervision at the rural site was easily established, as both the family physician and the obstetrician had extensive supervisory experience, and almost 18 months of evaluation data from the rotating residents were available to support adequate supervision. The plan for a shorter time spent in the medical center was to be facilitated by interactive videoconferencing, including the fellow as both learner and teacher in the regu-

Table 2. Goals for proficiency in maternity care.

- General fetal assessment, including parameters of gestational age estimation including ultrasound
- Performing a biophysical profile using ultrasound
- Indications for and interpretation of antepartum fetal surveillance (NST, CST)
- Components of routine prenatal and postpartum care and identification of high-risk situations and their initial management
- Comprehensive management of complicated obstetrics appropriately managed with the assistance of an off-site consultant (eg, diabetes, hypertension, IUGR, placenta previa, preterm labor and PPROM, STDs, breech at term)
- Recognition of abnormalities of labor progression and fetal monitoring and appropriate management measures
- Management of labor analgesia and SVD, including episiotomy repair
- Outlet vacuum extraction and outlet forceps
- Low transverse cesarean section in the patient at term
- Neonatal circumcision

NST = non-stress test
CST = contraction stress test
IUGR = intrauterine growth restriction
PPROM = preterm premature rupture of membranes
STD = sexually transmitted disease
SVD = spontaneous vaginal delivery

Table 3. The "practice-support" rural fellowship: a cost analysis.

For the site	Fellow, in Dollars	Junior Associate, in Dollars
Salary and fringe	60 K	150 K
Liability premium	6 K	15 K
Food, housing (AHEC)	8 K	0 K
	74 K	165 K
For the family medicine department		
Administrative		
Start-up (accounting, licensure, benefits, personnel), 60 hours		1.5 K
Maintenance, 2 hours/month		.5 K
Supervision		
Director's advisory, weekly conference calls x 2 MDs, 100 hours		9.0 K
Conference call (staff scheduling, university operator, long-distance) (AHEC)		5.0 K
Data entry, documentation system, secretarial support, 100 hours		1.2 K
		17.2 K

AHEC = Area Health Education Center

lar residency conferences. Once funding and practical issues dictated very little time at the medical center, other methods of indirect supervision by the director were implemented.

Funding

The entity providing the funding for a fellowship position must have some revenue stream unless dedicated funds from another source are available. For the existing maternity care fellowships, funding comes almost entirely from patient care revenues. Understandably, the position of the family medicine chair was that if departmental funds were used, the fellow would need to see patients in departmental facilities. Although this would facilitate the maintenance of general medical skills by the fellow, continuity would be difficult, and the existing facilities already had too many learners. In addition, every day spent away from the rural site diluted the fellow's opportunities to accomplish the goals shown in Tables 1 and 2. From the perspective of those at the rural site, if they were paying the fellow's salary, they needed the fellow to see patients locally. In the end, the decision was made to fund the direct costs of the fellowship entirely from the rural site, with a mix of practice and hospital funds. The indirect costs were borne by the department as "in-kind" expenses, supplemented by both direct and in-kind support from the local Area Health Education Center (AHEC), as shown in Table 3. Table 3 shows also an annualized comparison of the funding for the fellow with that for a junior associate, if the practice were to recruit one.

RESULTS

Curriculum

Evaluations from the fellow and all supervisors indicated that most of the general goals were accomplished, with the exception of the goal for managed care, as this did not arise during the year. The goals for maternity care were all accomplished (see the procedural list in Table 4). The population of patients was at quite high risk, as shown in the population descriptors in Table 5. Actually, these descriptors of the patients delivering in Jasper understate the high-risk status, as some of the patients at highest risk were transferred to referral centers for delivery. However, the fellow was actively involved in the assessment, initial management, and transition to tertiary care of these patients as well. Note that most of the patients received adequate prenatal care, testimony to the access provided by these family physicians. Table 6 describes the patients who were transferred for tertiary care.

Supervision

On-site supervision was effective and appropriate to the level of the learner. After performing a small number of routine deliveries and being supervised by the local faculty, the fellow then acted as independent supervisor for routine deliveries done by a family practice resident. All other procedures were performed by the fellow under the direct supervision of the family physician or obstetrician on-site. As an initiative from the site, a regular weekly Grand Rounds was established. Connected by telephone conference call to the director and a specialist chosen by the fellow, controversial or difficult cases were presented and discussed. At the rural site, 8 to 15 people including nurses, nurse practitioners and physician assistants, pharmacists, technicians, administrators, and physicians of several specialties generally attended; Category 1 continuing medical education credit was provided through a special arrangement with the AHEC. This afforded the best opportunity for the director to supervise remotely, as the fellow's management of the cases formed the basis for most conferences, allowing for assessment and feedback from the director. These conferences were well received, suggesting that hearing the consulting specialists compliment the local care made the rural providers feel more confident in their skills. The specialists also expressed new understanding for the situation and quality of care in Jasper, and appreciated receiving the complicated cases that were necessary for training their residents and fellows in the tertiary care center.

Funding

The costs shown in Table 3 on an annualized basis were approximately accurate during this first year of fellowship. The actual salary for fellows providing maternity care varies widely across the country, affected more by competition of recruitment than cost of living. A range of $35,000 to $120,000 was found in an informal survey by the director, so the $48,000 annual salary used in this budget was considered to be appropriate.

Table 4. Procedures summary.

Vaginal deliveries	116
Cesarean sections	66
Assisted deliveries*	13
Dilation and currettage	29
Tubal sterilizations	
At cesarean section	25
Immediate postpartum	10
Open bilateral tubal ligation (not postpartum)	3
Ectopic/salpingostomies	2
Amniocentesis	2
Circumcisions	
Mogen	37
Gomko	18
Plastibell	2

*Outlet vacuum extraction or forceps

Outcomes

The positive effects on the local community are difficult to quantify. In both written evaluations and interviews by the director, all providers indicated that the interest in improving the quality of patient care activities was augmented by having the fellow present. Her training in the Northeast brought some new perspectives to local providers. Most agreed that, rather than being perceived as a threat, her need to understand local routines of care and change them when appropriate was refreshing. Potential cultural barriers were easily overcome as the fellow was received warmly by the local community, with many patients expressing their preference to see her whenever possible. The epitome of this bonding process occurred when the fellow rode, in full western garb, in the annual rodeo parade to the cheers of the community. Perhaps the strongest measure of success was the fellow's decision to remain in Jasper as a full-time provider in the practice, serving as an active teacher in the fellowship for the subsequent year. The fellowship has now grown to encompass 2 positions in Jasper, and 1 each in 2 other sites in East Texas.

Table 5. Delivery population.

Population description	No.	(%)
Primipara	69	(38)
Teenage pregnancy (19 years or fewer)	49	(27)
Very young mother (<15 years)	15	(8)
Unmarried mother	78	(43)
Medicaid	160	(88)
Not insured	9	(5)
Inadequate prenatal care (<6 visits)	9	(5)
Fetal distress	58	(32)
Abnormal labor	54	(30)
Epidural anesthesia	46	(25)
Premature labor	41	(23)
Hypertension	30	(16)
Abnormal presentation	23	(13)
Anemia	19	(10)
Meconium staining	15	(8.2)
Diabetes	11	(6)
Postpartum hemorrhage	5	(2.7)
Post date	4	(2)
Postpartum infection	3	(1.6)
IUGR	3	(1.6)

IUGR = intrauterine growth restriction

Table 6. Patients transferred to The University of Texas Medical Branch at Galveston (N=39).

Transferring diagnosis*	No.
Preterm labor	12
PPROM	9
Oligohydramnios	6
PIH/HELLP	5
Fetal anomaly	4
Chronic hypertension	3
IUGR	2
Pneumonia	1
Seizure disorder	1
Polyhydramnios	1

* Some patients transferred with multiple diagnoses.

PPROM = preterm premature rupture of membranes
PIH/HELLP = pregnancy-induced hypertension/hemolysis, elevated liver enzymes, low platelets syndrome
IUGR = intrauterine growth restriction

DISCUSSION

This innovative method for conducting postgraduate training entirely in a rural area was successful both from training and practice-support perspectives. The approach has some similarities to the "apprenticeship" method of old. Some potential fellowship applicants have stated that if they were going to consider such an experience, they would just join an existing practice as a junior partner and not suffer the financial penalty of another year of training. The value of the experience summarized here from the fellow's perspective is that it provides another year of relatively "protected" practice for the development of skills and confidence in areas not currently provided by most residencies.

Although the focus was on maternity care, the fellow cared for 5 to 10 other inpatients daily during the year, including adult general medicine and pediatric patients, and worked in the office about 4 half-days per week. Even though her initial skills in these areas were well developed, the ability to care for these problems in a setting remote from consultants was a new experience for her. This resulted in a new "comfort zone" that ultimately led to her decision to practice in the rural area.

In a busy rural practice, a provider is often pulled among the intensive care unit, the office, and labor and delivery. A junior partner is required to respond first to what the overall practice needs her to do. However, in a fellowship setting, the learner has the freedom to choose the clinical activity that best addresses the learning objectives. In addition, the requirement of presenting difficult cases and researching the current management of each weekly, knowing that the director and consultant on the telephone will have high expectations for her, undoubtedly led to more efficient learning than would occur in a typical junior associate position.

After completing this first fellowship year, the obstetrician involved moved to another practice site. Having a board-certified obstetrician-gynecologist as a local faculty for such a fellowship is probably not a requirement. However, his enthusiasm, experience, and willingness to take the extra time to teach was critical in the first year of the fellowship. In the subsequent year, the recent graduate of this fellowship and the other fellowship-trained family physician with 5 years of practice experience in Jasper largely filled this role. There was some concern that approval of observed procedures by a board-certified obstetrician-gynecologist might be important to subsequent credentialing, especially in regions where family physicians have not routinely provided advanced maternity care. To address this need and to bring more depth of experience, an obstetrician-gynecologist with almost 30 years of practice experience was added subsequently as part-time local faculty for the fellowship.

Another lesson learned was that the fellow expressed the desire, retrospectively, to have spent some time at the academic center. Her opinion was that this would have been beneficial both for educational purposes as well as for enhancing the relationship between the rural hospital and the referral center. Despite frequent urging by the director for her to do so, the bonding to the local site was so effective that she found it difficult to be unavailable to her patients and colleagues for more than just an occasional 2- to 3-day break. She had already completed the Advanced Life Support in Obstetrics provider course as a resident, so she co-taught a course with the director during her fellowship. This not only provided a refresher for her to the content of the course but allowed her to meet others providing maternity care in the region.

The positive effects on the practice and the hospital were evident, with eventual agreement to continue sharing the full cost of 2 salaries for fellows. The question arises as to whether the continued affiliation with the university is advantageous enough to justify having to work with a large bureaucracy; contracting with a university provides some challenges. From the practice's perspective, having medical liability coverage for the fellow through the university is usually an advantage. From the fellow's perspective, the oversight and sanctioning of the training by a university medical center adds considerable credibility. Although, ultimately, the list of completed procedures is the most tangible product of the year, a letter and certificate signed by the local faculty, the director, and the department chair lend further credibility. Departmental faculty, especially the director, must feel comfortable with the level of supervision. This was accomplished by 3 to 4 site visits per year and the weekly conference calls. Technical limitations delayed the availability of interactive video with the site. When this becomes available, the director could directly observe operative procedures through a camera mounted on the operating room lights, as well as having the fellow participate more actively in medical center conferences (8).

Overall, the participants in this fellowship perceived a positive effect on recruiting and retaining local providers while providing a valuable postgraduate training experience. The relatively low cost of such an effort lends itself well to replication on a widespread basis. Probably hundreds of rural communities in the United States where 30 to 40 deliveries occur each month are actively seeking to recruit new providers. Where a supportive regional medical center can be connected with an interested local faculty and hospital, a special opportunity can exist to exert a positive effect on rural health care.

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Reversing the tide: emerging options for treating overactive bladder symptoms in women

GARY E. LEMACK, MD

The symptom complex of urinary urgency, frequency, nocturia, and urge incontinence, also known as the "overactive bladder" syndrome, affects the lives of millions of American women. As the symptoms are nonspecific, several different etiologies may be responsible. In many women, however, no discernible source can be identified. If a basic evaluation, including history, physical examination, urinalysis, and postvoid residual determination, fails to identify a source for the complaints, empiric treatment with behavioral intervention or a trial of medication may be offered to control symptoms. Certain patients will require a more detailed evaluation, particularly if conservative measures fail to provide relief. The role of advanced diagnostic strategies and the emergence of new treatment modalities are discussed.

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INTRODUCTION

Incontinence is thought to affect 13 million Americans, at a cost of at least $16 billion annually. For many patients with incontinence, the prospect of a solution other than staying home to avoid the embarrassment of frequent trips to the bathroom or using diapers daily to control episodes of leakage would be welcomed. For physicians, who are often frustrated by a sense of futility in treating this problem, a solution would be equally welcomed. Today, as we learn more about the causes for various types of bladder dysfunction that results in urgency and incontinence, more treatments become available, and several new solutions sit on the horizon. Hope exists for patients with bladder dysfunction who experience urgency, frequency, nocturia, and incontinence.

ETIOLOGY

The symptom complex of urinary urgency, frequency, nocturia and urge incontinence (sometimes called "overactive bladder") most typically affects women and the elderly. In contrast, stress urinary continence, which also most often affects women, is present when urinary leakage occurs with cough and other maneuvers that raise intra-abdominal pressures. Overall, most patients who are referred to an incontinence center have a mix of stress and urge incontinence, though usually a single particular symptom is predominant. Whether symptoms of overactive bladder are related to an intrinsic defect of the bladder (detrusor muscle) or to a more global defect in the innervation and activity of the pelvic floor musculature is currently a matter of much debate, and several different myogenic and neurogenic explanations have been proposed.

Certain conditions should always be considered in the patient with urgency, frequency, nocturia and urge incontinence before treatment aimed at the symptoms rather than at a definite cause is undertaken. Bladder infections are probably the most common cause of irritative symptoms, particularly when the onset is acute, and cultures should be sent to the laboratory before antibiotics are administered. Bladder tumors, stones, bladder outlet obstruction, and other inflammatory conditions of the bladder produce similar symptoms and should be considered if no infection is found or if a rapid response to culture-specific antibiotics does not occur. Patients with neurological processes such as cerebrovascular accidents, Parkinson's disease, spinal cord injuries, or multiple sclerosis often report urinary urgency, frequency, and incontinence; most often, however, studies may yield no clear etiology, and the treatment is directed toward relief of symptoms.

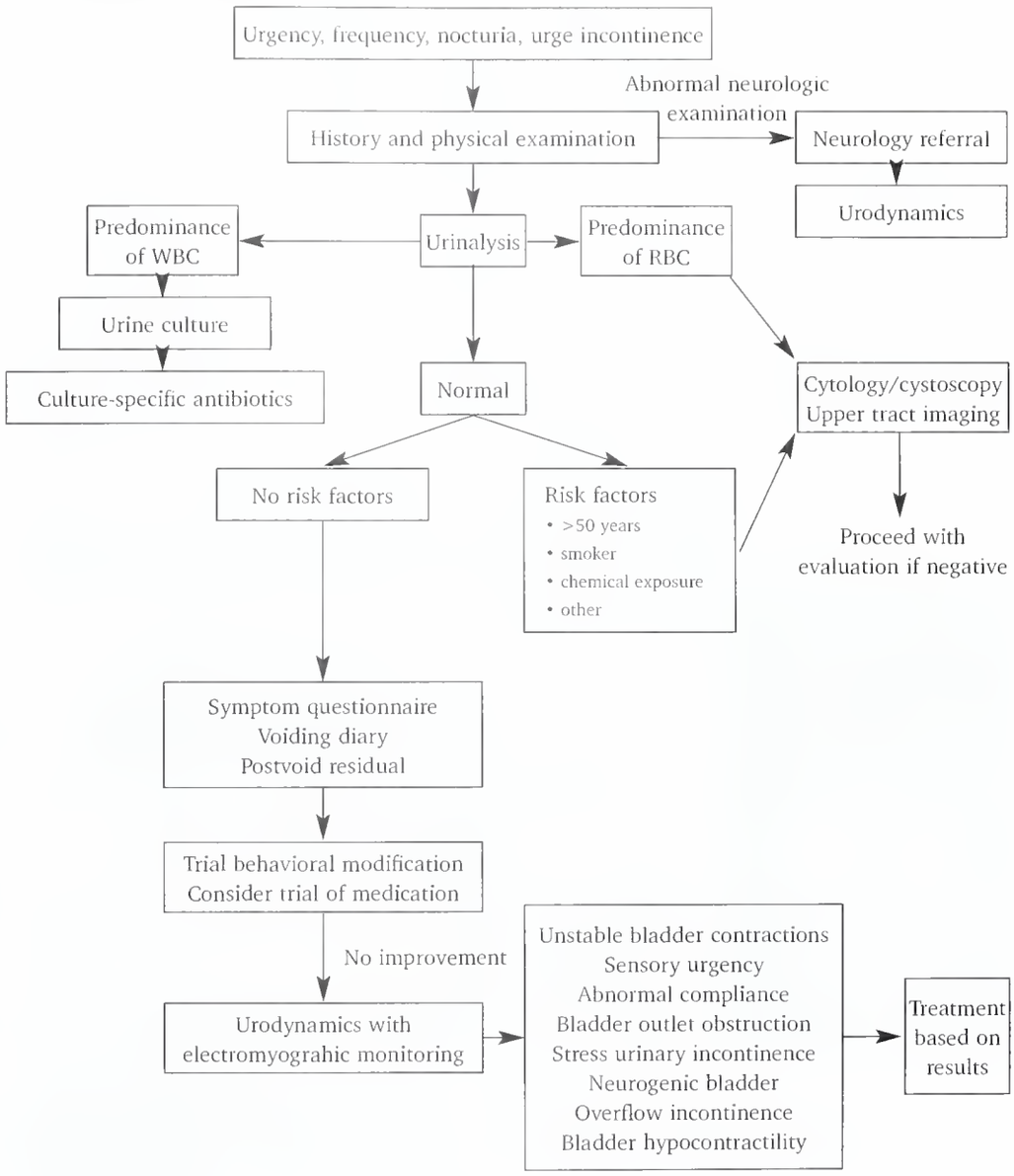
EVALUATION

Each new patient presenting with the symptom complex typified by urgency, frequency, nocturia, and urge incontinence should be evaluated thoroughly (Fig 1). In addition to a comprehensive history and physical examination, with particular emphasis on focused neurological and pelvic examinations, a urinalysis and, possibly, a determination of postvoid residual (by ultrasound) should be performed. Often, the patient will be asked to complete a validated questionnaire focusing on the problems affecting her, as well as a 3-day voiding diary to characterize the nature and severity of leakage episodes, and volume intake.

If the patient is considered to be at risk for bladder tumors (eg, older than 50 years, smoking history, or chemical exposure) and does not respond to conservative management (described later), a urology consult is advised. Cystoscopic examination may then be warranted to rule out the presence of bladder tumor. When intravesical find-

ings are normal, urodynamic testing may be required to determine the nature of the bladder dysfunction. During this test, bladder and rectal catheters, which monitor intravesical and intraabdominal pressures, are placed as fluid is instilled into the bladder and then as the patient voids. Surface or needle electrodes monitor electromyographic (EMG) activity of the pelvic floor and urethral sphincter during the entire process. On the basis of this test, several categories of bladder dysfunction can be discriminated and appropriate treatment can be advised.

Fig 1. Algorithm for treating symptoms of overactive bladder in women.



TREATMENT

Treatment for patients with urinary frequency and urgency starts generally as noninvasive and progresses to more invasive strategies if conventional measures fail (Fig 2). The first consideration for women presenting with this symptom complex should be to adjust the timing and extent of fluid intake. Often, this type of behavioral modification can alter the urinary patterns that most bother the patient. Dietary changes away from choices that can aggravate bladder instability (eg, caffeinated beverages) can improve quality of life. Limiting fluid intake in the evening or altering the timing of diuretic use (if medically advisable) can frequently reduce episodes of nocturia.

If these measures fail, medications are often offered to help relieve symptoms. Classical treatment has consisted of anticholinergic medications (eg, propantheline or hyoscyamine) or musculotropic medications (eg, oxybutynin). While often effective, these medications tend to have some side effects (mouth dryness and constipation), and more bladder-selective anticholinergic agents with fewer side effects (eg, tolterodine [Detrol]) have become available. Recent data suggest that the number of daily episodes of incontinence can be cut by more than 50%, while the number of episodes of nocturia can be similarly reduced after 4 months of therapy (1). A longer-acting form of oxybutynin (Ditropan XL) is now available that may improve compliance by reducing dosage to once daily and by limiting the fluctuations in blood levels seen with more frequent dosing. Clinical trials of potassium channel openers, which have been shown to reduce electrical excitability of the bladder smooth muscle in animal models, have begun recently, as have trials for muscarinic receptor-specific (M_3) anticholinergic medications that may further reduce the side-effect profile by decreasing nonspecific cholinergic blockade. Finally, if the patient's primary complaint is nocturia, either imipramine or intranasal desmopressin may help with nighttime urgency. Trials will be under way shortly to assess the efficacy of oral desmopressin for this indication.

If these medications fail, the patient should be referred to an incontinence center, where a more specialized ap-

Fig 2. Progression of treatment strategies for women with urinary urgency, frequency, nocturia, and urge incontinence.

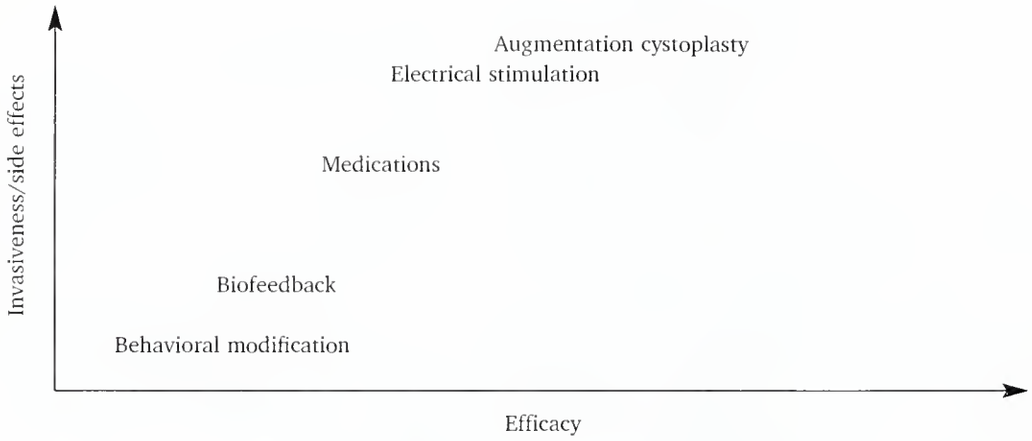
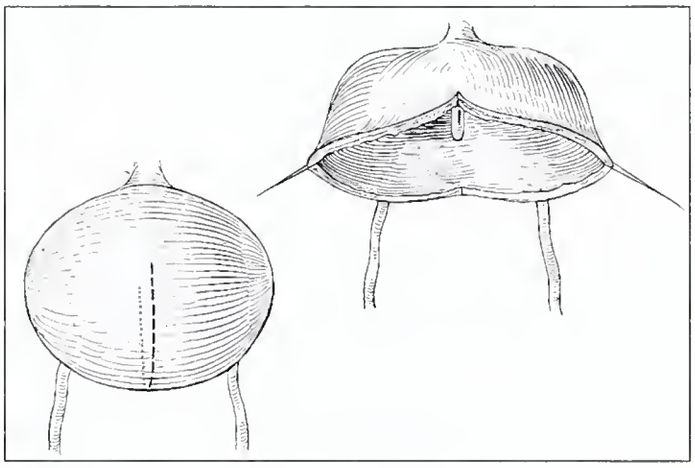


Fig 3. Augmentation cystoplasty. Bivalved bladder is shown at left, and bowel segment is then patched on to open bladder. Postoperative cystogram demonstrates large capacity, augmented bladder (right).



proach to diagnosis and treatment can be adopted. Often, the next step in managing these patients is biofeedback, during which the patient is taught how to selectively contract her pelvic musculature through the use of vaginal probes and EMG monitoring of the pelvic floor. Through progressive instruction, the patient is taught how to recognize successful recruitment of pelvic floor muscles; then she is encouraged to practice contracting them at home with a daily set of exercises. Repeated use of these muscles is thought to modulate the neurological cross-talk between the bladder, sphincter, and levator musculature, and to promote better bladder control. In 30% to 84% of patients, substantial improvements can be achieved, although complete resolution of symptoms is unlikely, even in extremely motivated patients, and ongoing treatment is required to maintain results (2,3).

More invasive approaches are available for patients who are refractory to behavioral modifications and medications, and who have severe urge incontinence caused by detrusor instability. During augmentation cystoplasty, a segment of bowel (usually ileum) is harvested and patched to the bisected bladder (Fig 3). By decreasing pressures generated during unstable bladder contractions and by increasing bladder capacity, continence can be achieved in more than 90% of patients undergoing this procedure. However, potential risks and complications, such as kidney or bladder infections and metabolic derangements, are involved; these need to be discussed before this approach is undertaken.

To avoid these risks, new forms of therapy such as electrical stimulation, which is thought to modulate the neural communications between the pelvic floor and bladder, have been advocated. Stimulation of the sacral nerves via a transcutaneous temporary stimulator has been shown to improve symptoms in approximately 60% of carefully selected, motivated women with refractory urge incontinence (4). If this procedure is successful, both a permanent sacral nerve root electrode and a subcutaneous stimulator can be implanted, and the patient is instructed how to control the unit with a hand-held activation device. While reported complications have been relatively minor and outcomes appear durable, mean reported follow-up has been relatively short (18 months). Finally, a new device that stimulates the tibial nerve at the ankle is currently being investigated for this same indication at several centers. Ultimately, repeated stimulation of this nerve is thought to promote bladder storage and emptying by neuromodulation.

CONCLUSIONS

More than just a cosmetic or social concern, the symptom complex of urinary urgency, frequency, and urge incontinence causes a financial, physical, and emotional drain on patients. As we begin to understand more about the processes that cause this syndrome, more options for treatment have been developed, and still more may become available in the near future. A stepwise approach to managing these patients is advocated, with increases in invasiveness being balanced by improvements in efficacy.

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4. Shaker HS, Hassouna M. Sacral nerve root neuromodulation: an effective treatment for refractory urge incontinence. *J Urol.* 1998; 159:1516–1519.

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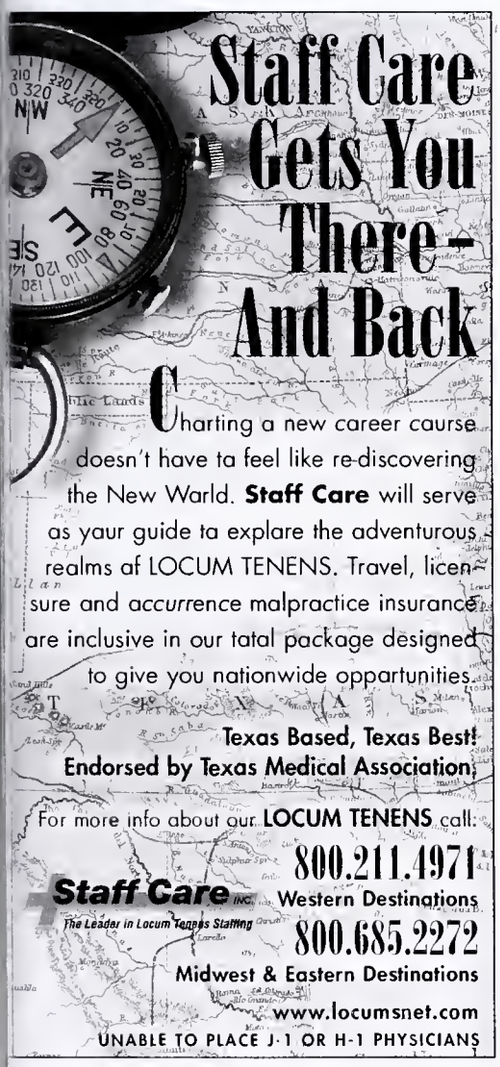

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February 2000	**Dec. 31, 1999**
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TexasMedicine

Here's what's coming in December's *Texas Medicine.*

Healing hands photo essay
Y2K preparedness
Honduras mission, part 2

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Southwestern Center for Minimally Invasive Surgery: Comprehensive Gynecologic Laparoscopy, Dec. 10-11 in Dallas. Course includes live surgery and/or video session, hands-on video-trainer workshop and an in vivo laboratory. Sponsored by The University of Texas Southwestern Medical Center at Dallas, Department of OB/GYN. Director: R. Coleman, MD. CME credit offered. Contact: Leah Cannon, (214) 648-3792.

The Alliance for Medical Management Education Degree and Certificate Program—Healthcare Financial Management, Jan. 9-14 at North Dallas Renaissance Hotel. The University of Texas Southwestern Medical Center at Dallas jointly sponsored with The University of Texas at Dallas. Directors: J. Burnside, MD; J. McCracken, PhD. CME and graduate academic credit offered. Contact: Paul Krawietz, (214) 648-3705.

Southwestern Center for Minimally Invasive Surgery: Surgical Education, Jan. 14 in Dallas. An introduction to surgical education for young academic surgeons who are interested in surgical education as part of their career path. Sponsored by The University of Texas Southwestern Medical Center at Dallas, Department of Surgery. Director: P. Bergen, MD. CME credit offered. Contact: Leah Cannon, (214) 648-3792.

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December 1999

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TMA Planner

November 12-13, 1999
TMA House of Delegates
Interim Session
Doubletree Hotel, Austin

February 24-26, 2000
TMA Winter Conference
Renaissance Austin Hotel

May 25-28, 2000
TexMed 2000
River Center and Convention Center,
San Antonio

November 1999

November 2	Plano	Care for the Caregiver
November 2	Houston	Alcohol and Other Drug Use Among Physicians
November 3	San Antonio	Medical Records Dos, Don'ts, and Other Intriguing Dilemmas
November 5-6	Dallas	Impairment Evaluation Under Texas Workers' Compensation
November 5-6	Irving	Texas Academy of Internal Medicine
November 8	Tyler	Compliance Plans: Truth and Consequences
November 9	Houston	Care for the Caregiver
November 10	Austin	Medical Records Dos, Don'ts, and Other Intriguing Dilemmas
November 11	Houston	Before You Sign on that Dotted Line
November 11	Houston	Policy and Procedure II: Employment Issues and Office Safety
November 11	Lufkin	Physician Stress and Burnout
November 12	Richardson	Oral Health in Cancer Therapy
November 15	Midland	Alcohol and Other Drug Use Among Physicians
November 17	Dallas	Medical Records Dos, Don'ts, and Other Intriguing Dilemmas
November 18	Corpus Christi	Policy and Procedure II: Employment Issues and Office Safety

December 1999

December 1	Corpus Christi	Medical Records Dos, Don'ts, and Other Intriguing Dilemmas
December 2	San Antonio	Policy and Procedure II: Employment Issues and Office Safety
December 3	Tyler	Oral Health in Cancer Therapy
December 8	Texarkana	Physician Stress and Burnout
December 9	Tyler	Policy and Procedure II: Employment Issues and Office Safety
December 16	Abilene	Policy and Procedure II: Employment Issues and Office Safety

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The healing touch

Take away all the fancy high-tech, high-dollar medical equipment and you still have the physician's hands, the essence of medicine. Our annual photo essay celebrates the healing touch of physicians.

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The Big Picture

Sundown at 10,000 feet near Cook City, Mont, by Roy L. Leamon, MD, Austin

If you would like to submit a photograph for The Big Picture, please send it to Laura J. Albrecht, Photo Editor, *Texas Medicine*, 401 W 15th St, Austin, TX 78701.

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Editor's Note

Although planning and executing the annual photo essay is a year-long process, the actual idea for the project can come in the blink of an eye. Or in this case, the stroke of a dog's head.

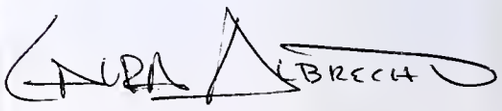
In my life away from Texas Medical Association, I train therapy dog teams who visit residents in nursing homes, rehabilitation facilities, shelters, and other health care facilities. On one particular visit, I watched as an elderly resident with Parkinson's disease reached out with her frail, trembling hand to touch my therapy dog, Shadow. As she grasped the black lab's steady, boxy head, the trembling at least for a moment ceased. Then she smiled, satisfied and comforted through a simple touch.

After experiencing that little miracle, I began to think about the physician's world of touch.

This year's photo essay takes you up close and personal and focuses on "The Healing Touch." Austin photographer Susan Gaetz directed her lens on whom and what physicians touch — patients, charts, instruments, phones, books, toys, x-rays, computers, and medications.

A special thanks to the physicians and staff at Scott & White Memorial Hospital & Clinic in Temple who welcomed *Texas Medicine* with open arms to make the photo essay a reality.

I hope these photographs will help you appreciate the healing touch of Texas physicians.



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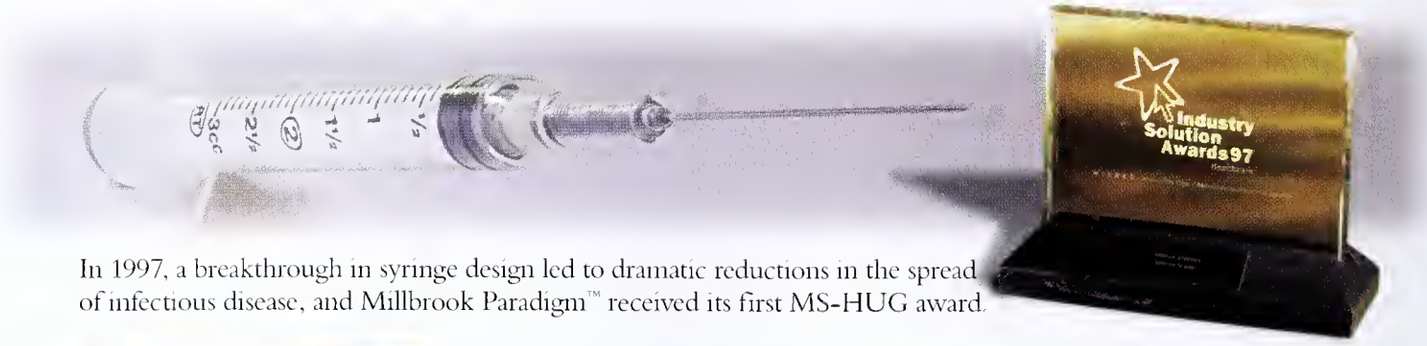

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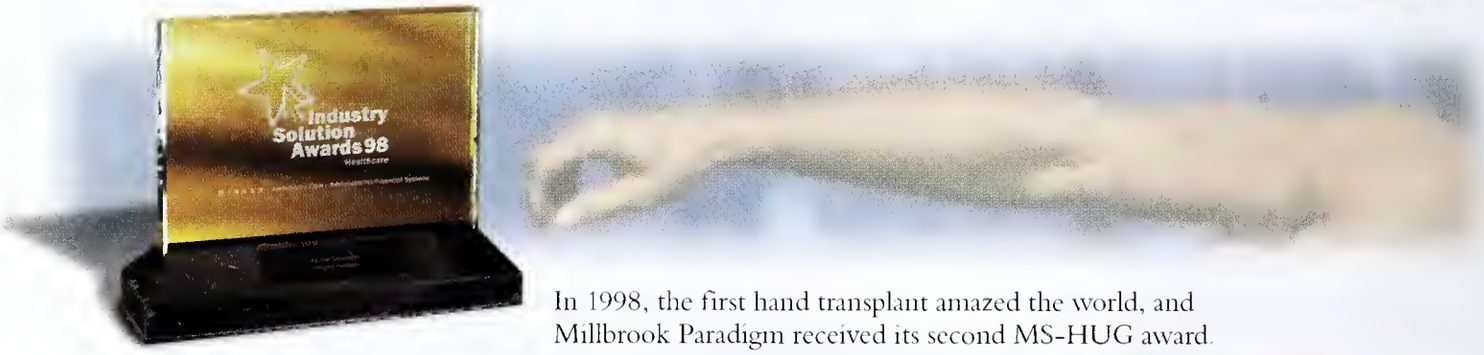
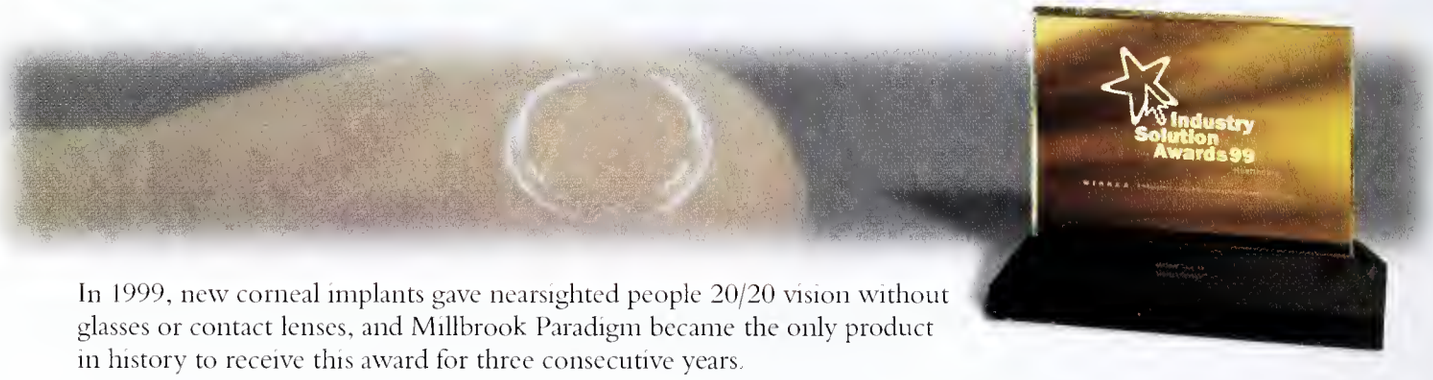


In 1998, the first hand transplant amazed the world, and Millbrook Paradigm received its second MS-HUG award.



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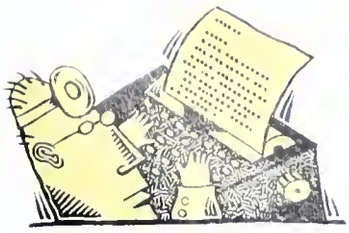

Letters

Drifting toward socialized medicine

In his commentary (October 1999 *Texas Medicine,* pp 13–16), Timothy Gorski, MD, correctly states, "The future of American medicine depends on how some very serious questions are answered." In his article, Dr Gorski identifies the essential crucial issue: "Do people have a right to medical care?"

Rather than identifying the moral principles upon which the concept of "rights" is based, however, Dr Gorski asserts, "Life, liberty, and the pursuit of happiness come to mind when the subject of human rights is raised. But these amount essentially to the right to be left alone." Dr Gorski goes on to beg the question by posing several hypothetical questions beginning with, "If a fundamental right to medical care exists . . ."

Health care is not a right and no "fundamental right to medical care exists." A political right derives from the moral principle that it is both necessary and good for an individual to act to live (thus a right to life), that in order to live it is necessary to be free to act to live (thus a right to liberty), and that the moral purpose of an individual's life is the freedom to pursue one's own happiness (thus the right to the pursuit to happiness).

There is no moral or political right to the products or services of others, including health care. Attempting to grant a nonexistent right to the product or service of others necessarily means denying the individual rights of those who produce the service or product and reducing them to the status of slaves.

In the context of the current health care debate, this means the enslavement of physicians to the government and ultimately the destruction of medicine. Rights do essentially mean "the right to be left alone" from the government. Government exists to protect individual rights, not to destroy them by attempting to arbitrarily create nonexistent rights.

In other words, physicians have the right to freely produce health care and to treat patients, free from government regulation and the threat of coercion and force. For the same reasons, an individual patient carries financial responsibility for health care and has the right to see the physician of his or her choice, to decide with the physician what treatment is best and under what circumstances and by whom this treatment will be rendered, free from government regulation or the threat of government force.

The patient-physician relationship is based on the trader principle, which means that each party engages in the relationship freely, without the threat of government force and regulation. This relationship is a keystone for the practice of medicine. If this relationship is destroyed through the arbitrary use of government force, the result is the destruction of medicine for patients and physicians.

There is no moral or political right to the products or services of others, including health care.

A free market in medicine is the only moral and practical means of ensuring quality health care. Consistent with this fact are such "reforms" as the full expansion of medical savings accounts and granting 100% tax-deductibility to individuals for health insurance premiums and health care costs. Unless physicians, the public, and politicians embrace free market "reforms" in medicine, America's drift toward socialized medicine and the consequent destruction of medicine will continue.

Richard G. Parker, MD
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Letters

Organized medicine's responsibility

I respectfully disagree with Dr Gorski's commentary (October 1999 *Texas Medicine,* pp 13–16). It is self-serving for a physician to claim that organized medicine has nothing to do with the current mess we find ourselves in. Organized medicine represents the majority of physicians, who individually care for their patients but collectively are extremely conservative politically and into denial when it comes to the public health and individual health of the less fortunate members of our community and society.

Organized medicine fought the establishment of private health insurance in the 1930s, successfully defeated President Truman's proposal for national health insurance in the 1940s, and unsuccessfully opposed Medicare in the 1960s. This lack of responsible leadership created a vacuum filled by politicians, employers, self-serving capitalists, and an entourage of know-nothing experts in health care.

This is not the first time in our country's history that a lack of leadership has created a vacuum with terrible consequences. A lack of leadership and social injustice go hand-in-hand. Slavery, segregation, anti-Semitism, gay bashing, voting rights exclusively for men, and other injustices did not disappear or lose face by victims complaining. Defeat of social injustice, including profit care, requires dedicated leadership, integrity, and education of the public about the harm inflicted on all of society by injustice such as profit care. In addition to attacking injustice, responsible leadership proposes meaningful solutions to problems.

Numerous times in this publication I have advocated Americare, quality universal health care for all. Dr Gorski lets organized medicine and its leaders off the hook for the current mess. Organized medicine has been part of the problem; it's now time for organized medicine to be part of the solution.

Gerald Frankel, MD
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An honest response

Dr Clanton's response on behalf of the "Blues" is strikingly honest ("Dr Clanton Responds," October 1999 *Texas Medicine,* p 11). It says simply that Blue Cross and Blue Shield's payment policies do not need to make sense and the company doesn't intend to change them anytime soon. This is one of the reasons we have resigned from the Blue Cross and Blue Shield network.

I would also caution providers to analyze what they are getting paid by this company and other payers under managed care contracts. After they finish nipping and shaving the bills, it never seems to add up to as much as the limited price schedule we agreed to. We found our actual collections were below Medicare from 5 of 10 carriers even though their reimbursement schedules seemed fair when we signed on.

J.E.B. Johnson, MD
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Lake Jackson, TX 77566-6201

September issue commended

The September 1999 issue of *Texas Medicine* deserves applause. The article on physician report cards ("Physician Profiling," pp 44–47) points out the serious problems of measuring physician performance against a limited database and the agenda of ambitious meddling politicians. As a member of the Peer Review Subcommittee of the Texas Health Care Information Council (THCIC), I attended two meetings where we vigorously criticized the methodologies of the THCIC, and our committee was promptly put into retirement. When criticism of the health care system begins and the mud starts to fly, more than managed care gets dirty. Has someone forgotten that physicians and hospitals are part of managed care?

"Women in Medicine" (pp 34–43) avoided gender polemics and stuck to an important development in medicine. The article also featured physi-

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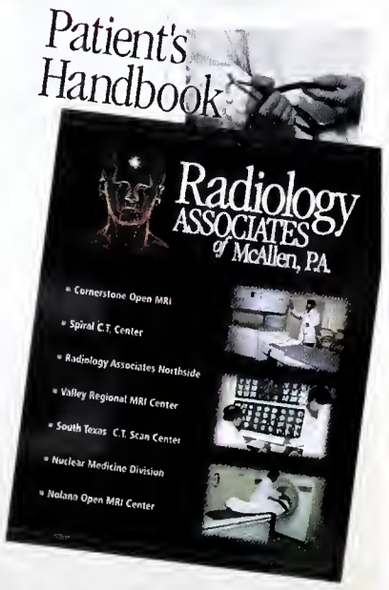

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cians who first are good human beings. Thanks for passing on the propaganda opportunity.

"Heart to Heart" (pp 48–51) emphasizes what should be our public health agenda. Lifestyle makes more difference than the latest fancy medical treatment or procedure.

The most important article in the issue was "Why People Get Sick" (pp 53–56). The effect of socioeconomic status on health and longevity has been studied extensively in the British and American medical literature for a number of years. If you match individuals for education and income, race and ethnicity disappear as factors in health outcomes.

The exceptional experience of Hispanics in Texas is parallel to a pattern that is seen in first-generation Japanese and Chinese residents of America, who maintain their good health and life expectancy, independent of education and income status. Family counts.

Marsha Angell, MD, editor of the *New England Journal of Medicine,* said in 1993: "Socioeconomic status emerges as one of the most important influences on mortality and morbidity. . . . No one knows quite how it operates." Most important of all, she said, "We are too quick to medicalize many social ills" (1).

In a study published in the *New England Journal of Medicine* in 1997, Lynch et al found that ill health and socioeconomic status were closely linked and were more important than lifestyle choices (2).

The work being done in Houston will expand our knowledge of this important phenomenon. Social conditions and people's perception of the quality of their own lives may have a lot more to do with how long they're going to live than even their lifestyles or the medical care they receive.

John Dale Dunn, MD, JD
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2. Lynch JW, Kaplan GA, Shema SJ. Cumulative impact of sustained economic hardship on physical, cognitive, psychological and social functioning. *N Engl J Med.* 1997;337:1889–1895.

Commentary

Why politics?

By David Duffner, MD, MBA

"Politics makes strange bedfellows," the old adage goes. And perhaps to many, none stranger than physician involvement with politicians.

Medicine is the healing art, both humanistic and noble, based on science, with the highest ethical standards of any profession, and has one overriding goal — the well-being of our patients. Politics to many seems adversarial and at times self-serving and ignoble, based on cynical manipulation of public opinion and institutions. While politicians are incorrectly perceived as "ethically challenged," it is easy to understand why many physicians are turned off and disinterested. But it is the Texas Legislature and the US Congress that primarily determine the rules by which we practice medicine.

There are many compelling reasons why physicians should become involved in politics. Indeed, our larger role in society demands it. Politics drives the process that sets public policy.

Consider the public policy issues that confront our profession:

- What kinds of health care services will exist in our society?
- Who will receive them and on what basis?
- Who will deliver them?
- How will the burden of financing them be distributed?
- How will the power and control of those services be distributed?

The answers to these questions are ultimately expressed as public policy regarding the allocation of scarce resources. Health care is a high priority, but it must compete with other interests, such as defense, public safety, and education. Such competition for resources is essentially political. And politics drives the process that determines public policy. It is in this context that physicians have an ethical imperative to become active in politics.

This is expressed in the American Medical Association's Principles of Medical Ethics, which says, "A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient." If we physicians care about our patients and our profession, we must engage health care-related public policy issues through involvement in the political process.

Fortunately, medicine's involvement in the political process works. Look at what has been accomplished in Texas over the past 10 years:

- *Reform of the Texas Supreme Court.* In the famous *60 Minutes* segment in 1987, Mike Wallace asked, "Is justice for sale in Texas?" In fact, the Supreme Court at that time was essentially owned by the plaintiff's attorneys and acted like a branch office of the Texas Trial Lawyers Association. When Mr Wallace revisited the issue in October 1998, *60 Minutes* concluded that although the Supreme Court was still subjected to the influence of big contributors because of the financial requirements of very expensive partisan elections, it is no longer corrupt. The distribution of millions of our TEXPAC slate cards has reversed the tide that made Texas a national haven for litigation. The unprecedented achieve-

There are many compelling reasons why physicians should become involved in politics. Indeed, our larger role in society demands it.

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ment of the Texas Medical Association and its alliance is a national model, copied by dozens of state tort reform movements.

- *Reform of the Texas Senate.* Due to the arcane Senate rules that require two thirds of its members to consent before a bill can reach the floor for a vote, it takes only a third to block legislation. In the 1980s, the trial lawyers had such a block. That has changed because of the increased activity of a coalition of conservatives and business groups interested in tort reform.
- *Passage of tort reform by the 1995 legislature.* The second wave of the malpractice crisis hit Texas in the 1980s because the Supreme Court gutted the medical malpractice reform bill previously passed by the 1977 legislature. The influence of Governor Bush and the pro-business coalition led by TMA and the Texas Civil Justice League resulted in reforms that have greatly improved the litigious environment.
- *Passage of managed care reform by the 1997 legislature.* Texas led the nation in passing sweeping reforms that provide due process for patients and physicians and hold managed care organizations accountable for negligent denial of services. This legislation has become a model for other states and the Congress.
- *Passage of the Physician Negotiation Bill.* Passed by the 1999 legislature, this bill is another landmark law that seeks to "level the playing field" in managed care.

These are only a few of countless legislative and political accomplishments attributable to the aggressive, proactive political actions taken by physicians and their spouses at the grassroots level. TEXPAC works to preserve the patient-physician relationship at the core of the health care system in Texas and America. If you are not a TEXPAC member, you should be. You owe it to your patients and your profession. ★

Dr Duffner, an orthopedic surgeon in Tyler, is the chair of TEXPAC.

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An exemplary medical career of more than 50 years and tireless public service have earned Dallas pediatrician **Ruth I. Allen, MD,** the Dallas County Medical Society Alliance's 1999 Aesculapius Award. She received the award — named for the Greek god of healing — at the alliance's fall luncheon in November.

James Brodsky, MD, Dallas, is the new treasurer-elect of the American Orthopaedic Foot and Ankle Society. Dr Brodsky is clinical associate professor of orthopedic surgery at The University of Texas Southwestern Medical Center.

Gerardo Cabrera-Meza, MD, has been appointed director of the international program at the Newborn Center of Texas Children's Hospital in Houston.

Fred F. Ciarochi, MD, Dallas, has been elected to the Southwest Medical Foundation Board of Trustees. He is president-elect of the Dallas County Medical Society.

Four physicians have received the Laureate Award of the Texas Academy of Internal Medicine, the Texas Chapter of the American College of Physicians-American Society of Internal Medicine (ACP-ASIM). They are **Jerry C. Daniels, MD, PhD**, Galveston; **John S. Fordtran, MD**, Dallas; **Robert J. Hall, MD,** Houston; and **Lloyd W. Kitchens, Jr, MD**, Dallas. The Laureate Award honors ACP-ASIM fellows and masters who have demonstrated an abiding commitment to excellence in patient care, education and research, and service to their communities and ACP-ASIM.

Jerry C. Daniels, MD

John S. Fordtran, MD

Robert J. Hall, MD

James C. Hoyle, MD

Lloyd W. Kitchens, Jr, MD

Rodney Rohrich, MD

Dr Daniels has also assumed the presidency of the Texas Academy of Internal Medicine. Other officers are **Phillip Cain, MD,** Temple, president-elect; and **Wayne J. Riley, MD, MPH,** Houston, secretary-treasurer.

Michael E. DeBakey, MD, received the Lifetime Achievement Award for Science and Technology from Children Uniting Nations last month in New York. Dr DeBakey is chancellor emeritus of Baylor College of Medicine and director of The DeBakey Heart Center at Baylor and The Methodist Hospital in Houston. The award cited his life-changing accomplishments in medicine and technology. He was one of eight recipients of the award presented the night before the United Nations International Day for Tolerance. Among the other recipients were former Soviet Premier Mikhail Gorbachev and Nobel Peace Prize winner Bishop Desmond Tutu, who were recognized for political leadership and social activism, respectively.

The American Cancer Society, Texas Division, has elected **Lawrence Frankel, MD**, Temple, president, and **Mark Clanton, MD**, Dallas, vice president.

The Texas Chapter of the American Academy of Pediatrics has elected **James C. Hoyle, Jr, MD,** Houston, as president, and **Dale Coln, MD,** Dallas, as president-

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elect. Other officers elected include **Kenneth E. Matthews, MD,** Bryan, chapter chair; **Robert H. Squires, Jr, MD,** Dallas, alternate chapter chair; and **Beverly L. Koops, MD,** Austin, secretary-treasurer. Elected chair, District 1, was **Alma C. Golden, MD,** Galveston, while **Anthony C. Kimbrough, MD,** Austin, was elected alternate delegate to the TMA House of Delegates. Elected board members-at-large were **Ernest D. Buck, MD,** Corpus Christi; **Carlos A. Gutierrez, MD,** El Paso; and **Richard M. Lampe, MD,** Lubbock. **Nancy Kellogg, MD,** San Antonio, received the 1999 Executive Board Award for her volunteer efforts.

Austin surgeon **Thomas D. Kirksey, MD,** received the Travis County Medical Society's Gold Headed Cane as its 1999 Physician of the Year.

Texas A&M University's Association of Former Students has presented the 1999 Distinguished Faculty Achievement Award to two faculty members of the Texas A&M University System Health Science Center College of Medicine. The recipients are **Gary C. McCord, MD,** assistant dean for student affairs and admissions, and professor of radiology and human anatomy and medical neurobiology at the College Station campus; and **Samuel K. Snyder, MD,** professor of surgery at the Temple campus. The awards recognize superior classroom teachers whose skills and commitment exemplify the meaning of teacher-mentor.

Rodney Rohrich, MD, Dallas, received the Sioux Award, the highest honor presented by the University of North Dakota (UND) Alumni Association, in October. The award recognizes UND alumni who have distinguished themselves in their chosen fields. Recipients are selected based on achievement, service, and loyalty. Dr Rohrich earned a bachelor's degree in medicine from UND in 1977. He is now professor and chair of the Department of Plastic and Reconstructive Surgery at The University of Texas Southwestern Medical Center at Dallas.

Former Texas Medical Association Secretary-Treasurer **George Thannisch, MD,**

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Lufkin, has received the Sidney Kaliski Award from the Texas Pediatric Society for his contributions to the health and welfare of Texas children. In addition to serving as TMA secretary-treasurer, Dr Thannisch was a member of the Texas delegation to the American Medical Association for 18 years and a member of the TMA Board of Councilors for 2 years. He retired in 1995 after 37 years of medical practice.

Kern Wildenthal, MD, president of The University of Texas Southwestern Medical Center at Dallas, has been elected to the Institute of Medicine. He is the 13th UT Southwestern physician-scientist elected to the prestigious organization charged with addressing national health issues. A component of the National Academy of Sciences, the Institute of Medicine shapes policies affecting public health and advises the federal government on issues regarding medical care, research, and education. Selection requires international distinction in science, clinical medicine, public health, or medical administration.

James Willerson, MD, Houston, is among six graduates of The University of Texas to receive the 1999 Distinguished Alumnus Award. Dr Willerson received a bachelor of arts degree from UT in 1961. He is professor and chair of the Department of Internal Medicine at UT-Houston Medical School, and medical director and chief of cardiology at the Texas Heart Institute.

Deaths

Otis Edward Cutler, MD, 63; Texarkana; University of Arkansas for Medical Sciences College of Medicine, 1965; died April 3, 1999.

Richard C. Douglas, MD, 84; Lubbock; The University of Texas Medical Branch at Galveston, 1938; died September 23, 1999.

Mervin Edward Fatter, MD, 84; Austin; Tulane University School of Medicine, 1938; died September 20, 1999.

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Lewis Woron Leskin, MD, 86; Waco; University of Maryland School of Medicine, 1937; died September 23, 1999.

Henry E. Martinez, MD, 69; Amarillo; Indiana University School of Medicine, 1956; died September 28, 1999.

James Elisha McLaughlin, MD, 65; Groves; Tulane University School of Medicine, 1958; died September 15, 1999.

John Howard O'Donnell, MD, 49; Houston; The University of Texas-Houston Medical School, 1974; died September 14, 1999.

Morris Sanders, MD, 74; Dallas; University of Chicago Medical School, 1952; died September 15, 1999.

Jack Quimby Sloan, MD, 80; Waco; Tulane University College of Medicine, 1944; died September 3, 1999.

George Warren Thomson, MD, 78; Fair Oaks Ranch; University of Chicago School of Medicine, 1951; died July 18, 1999.

Norman Terry Tompkins, MD, 66; Gainesville; Louisiana State University School of Medicine in New Orleans, 1959; died October 2, 1999.

Edward White, Jr, MD, 73; Dallas; The University of Texas Medical Branch at Galveston, 1953; died August 30, 1999.

James Pitchford Wills, Jr, MD, 65; Beaumont; Louisiana State University School of Medicine in New Orleans, 1962; died June 4, 1999.

Rudolph Felix Zepeda, MD, 83; Houston; The University of Texas Medical Branch at Galveston, 1941; died September 21, 1999.

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Texas Medicine Rounds

AMA, Intel developing system to protect Internet communications

When you or your patient press that computer keypad button to transmit medical information over the Internet, do either of you really know who else might see it? At this point, the answer is no.

With the use of the Internet in health care exploding almost exponentially, the need for secure transactions is becoming vital. That's why the American Medical Association is working with the Intel Corporation to develop a new electronic credential to protect the privacy of physicians and patients when they use the Internet to send and receive medical information.

Digital credentials — which uniquely identify individuals over the Internet — will be issued to physicians early next year, providing a more reliable authenticator than a password for secure Internet transactions. Testing of a prototype for physicians began in October.

The credential will allow physicians to take advantage of online physician services that require identity authentication. It also will be recognized by participating consumer health care-related companies that wish to offer trusted doctor-patient interactions online.

The authentication service announcement was made in October at Internet Health Day II in New York City, created by Intel and sponsored by AMA. Intel and AMA are working with physicians and health care industry leaders to explore how the Internet is impacting the practice of medicine and changing the way consumers access health information, products, and services. (See "Internet: Get On or Get Out," November 1999 *Texas Medicine*, p 18.)

At the same time, Healtheon/WebMD announced it would accept the AMA physician credential to allow secure online transactions between physicians and service providers such as hospitals, labs, and pharmacies. And, MedQuist announced it will accept the credential to provide physicians and hospitals with the ability to store and retrieve patient charts over secure Internet connections.

In working with AMA, Intel has launched a new business known as Internet Authentication Services (IAS). It develops and operates authentication services for associations, organizations, and e-Health sites that want to offer branded e-Health credentials to their users. IAS enables remote credential retrieval when users need access from a different computer and performs maintenance to keep the credentials current. It does not collect, store, or manage health care information, and e-Health sites do not access the credential user's security information.

With the use of the Internet in health care exploding almost exponentially, the need for secure transactions is becoming vital.

"The potential for the Internet to be used to obtain lab results, send prescriptions to pharmacies, and receive patient files makes it vitally important that systems are in place to ensure that the patient's privacy and confidentiality are protected," said Richard Corlin, MD, speaker of the AMA House of Delegates. "By authenticating the identity

of the physician and ensuring the privacy of the patient, you enable a wide variety of routine medical transactions to occur online, benefiting busy physicians and enabling better patient care."

Dr Corlin predicted that in the next decade, "physicians will routinely navigate cyberspace with important information about patients and their care — and the AMA needs to take the lead role in determining how best to do that securely. By working with Intel to deliver AMA physician credentials, the AMA is anticipating the needs of our patients and our members, and rising to meet those needs."

Ronald J. Whittier, senior vice president and general manager of Intel Content Services, said, "Making the Web a more trusted place is key to helping the health care industry move to the Internet. We are enabling a new level of trust for e-Health services that can make doctors more efficient, reduce health care costs, and improve patient satisfaction and care."

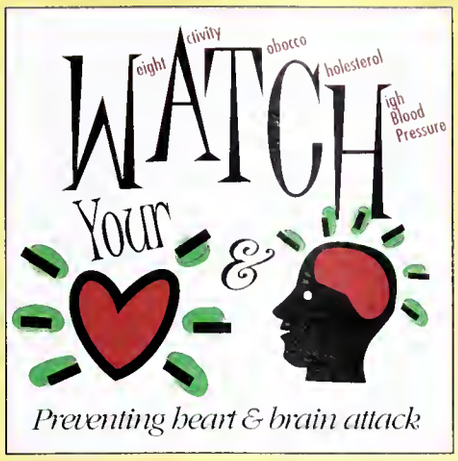
AMA's decision to provide digital credentials is an outgrowth of the "Electronic Data Interchange Report" issued by the AMA Council on Medical Service in 1998. The council recommended that AMA establish consensus for electronic storage and transmission of medical records to protect patient privacy.

In a related development, AMA announced that it was joining with six national physician associations to launch a health information and communication site on the Internet. The site, www.medem.com, will be available early next year.

Joining AMA in establishing the site are the American Academy of Ophthalmology, American Academy of Pediatrics, American College of Allergy, Asthma and Immunology, American College of Obstetricians and Gynecologists, American Psychiatric Association, and the American Society of Plastic and Reconstructive Surgeons.

The site will provide patients with the most credible, trustworthy, and high-quality information on the Internet, says AMA Trustee William H. Mahood, MD. Patients and physicians will be able to communicate with each other confidentially through the Web site. ★

PROJECT WATCH



Help your patients WATCH their hearts

It may seem like a daunting task to convince patients to make real changes in behaviors that are putting them at risk for heart disease or stroke. But patients will listen if physicians demonstrate a sincere concern for their patients.

"The key to getting any patient to change his or her behaviors is having the patient trust the physician and developing that good doctor-patient relationship so that the patient knows the physician really is concerned about that individual's health," said TMA President-Elect J. James Rohack, MD. Advice on smoking, obesity, lack of exercise, or other risky behaviors will simply "go over the patient's head" if it is delivered in a way that gives the appearance "that one really isn't compassionately concerned about the individual's health," he said.

The Temple cardiologist joined TMA President Alan C. Baum, MD, in unveiling Project WATCH at TMA's Fall Conference in September. Project WATCH is a heart disease and stroke prevention education initiative that focuses on the risk factors of weight, activity, tobacco, cholesterol, and high blood pressure.

Here are a few techniques Dr Rohack uses to help patients alter their risky lifestyles:

- Urge patients to increase their exercise by building workout time into their schedules. Thirty minutes of aerobic activity three times a week is not a big commitment, but Dr Rohack says patients have to make it part of their routine — even block off the time like they would for an appointment.
- Ask smokers to take the amount of money they spend on cigarettes every day and throw it into a jar. Then, take a look everyday at how much money they could save by quitting or reducing this habit.
- If smokers can't quit "cold turkey," suggest they reduce the number of cigarettes they smoke normally by one a day until they can quit altogether.
- Finally, don't forget the follow-up. Periodically check cholesterol levels. Challenge patients who continue to smoke or congratulate them if they've cut back or done a better job of controlling their weight.

"While we don't push the patients over the edge, we do continually remind them of the anticipated outcome if they don't make a behavioral change," Dr Rohack said. "The important message I want them to hear is that they can reverse heart disease that has already developed or prevent it from occurring in the first place, but it is something that one has to be committed to." ★

"The key to getting any patient to change his or her behaviors is having the patient trust the physician and developing that good doctor-patient relationship."

WEB SITES OF INTEREST TO TEXAS PHYSICIANS BY JENNIFER OWNBY

MedBytes

The Internet holds a world of information about the infamous year 2000 (Y2K) bug and its potential problems. This month's "MedBytes" offers some sites that give practical information for dealing with Y2K problems in health care and other industries.

Health care Y2K sites:

- **American Medical Association (www.ama-assn.org/notmo/y2k/):** Designed to prepare physicians for Y2K, the AMA site contains frequently asked questions about the millennium bug and a solution center.
- **Healthcare's Year 2000 Information Clearinghouse (www.rx2000.org):** You can join a Y2K health care discussion forum, check out the latest schedule for the Healthcare Year 2000 Special Interest Group, and explore the section titled "Year 2000 Self Help for Health Care Organizations" on this site.
- **Health Care Financing Administration (HCFA) (www.hcfa.gov/y2k/):** This site provides Y2K-related advice from HCFA, including steps you need to take to get ready for the millennium, and Medicare-, Medicaid-, and managed care-related information.
- **American Hospital Association (AHA) (www.aha.org/y2k/Intro.html):** This site shows the results of an informal survey conducted this summer on how prepared AHA members are for the turn of the century.

Other Y2K sites of interest:

- **AutoTester Inc (www.autotester.com):** On this site, you can explore automated testing solutions to reduce the amount of time and resources required to make sure your systems work for the millennium.
- **Comlinks.com (www.comlinks.com):** Hosted by Alan Simpson, a leading spokesman on international year 2000 issues since 1995, the Comlinks site houses Y2K frequently asked questions and press coverage summaries.
- **DFW (Dallas-Fort Worth) Prep 2000 (www.dfwdama.org/html/prep2000.html):** DFW's Data Management Association offers examples of how Texas companies are dealing with the Y2K problem, as well as a calendar of the group's year 2000 meetings on this site.
- **The GartnerGroup (gartner5.gartnerweb.com/gg/static/itjournal/testimony1.html):** Learn how the GartnerGroup is helping Congress tackle the year 2000 bug with this Web report.
- **Small Business Administration (SBA) (www.sba.gov/y2k/):** Visit this site to check out the SBA's "Y2K jumpstart kit."
- **Westergaard Year 2000 (www.wbn.com/y2ktimebomb/index.htm):** You can register for a Y2K daily e-mail alert and explore the millennium bug's effects on the economy and technology on Westergaard's site.
- **The Y2K Law Site (www.y2k.com):** This site has been examining the legal ramifications of the Y2K problem since 1996.
- **Year 2000 Information Center (www.year2000.com):** Y2K wire reports, conferences, products, tips, links, cartoons, and even stocks pop up on this Web site.
- **ZDNet Y2K Survival Kit Column (www.zdnet.com/anchordesk/story/story_2318.html):** Jesse Berst, editorial director of the ZDNet AnchorDesk, takes you through his best Y2K tips and provides more Y2K links.

TMA's Cyber Sweepstakes hits December

Be sure to drop by the TMA Web site at **www.texmed.org** before December 31 to sign up for TMA's latest Cyber Sweepstakes. TMA members who provide or confirm their e-mail addresses through the "Members Only" section before the end of this month are entered automatically to win a Palm V ultrathin organizer with razor-sharp LCD screen. Your e-mail address will be used to contact you with breaking health care news.

MedBytes is a quick look at new, or newly discovered, Web sites of interest to Texas physicians. The column also highlights features of the TMA Web site at www.texmed.org. If you know of some cool medical sites or have questions about how to use the TMA Web site, e-mail jennifer_o@texmed.org. Publication of information about Web sites in this column is not to be considered an endorsement or approval by the Texas Medical Association of the sites or sponsors, or of any products or services involved.

TMA physician survey scheduled for January

Want to express your opinion on the state of health care? You may get the chance next month when the Texas Medical Association conducts its biennial survey of physicians.

A random sample of physicians will be selected by TMA staff this month to receive a letter notifying them that they are on the list of possible survey participants. Then, in January, 600 physicians on the list will be asked to participate in a 20-minute telephone interview conducted by a survey firm.

Donna Kinney, manager of regulatory analysis and advocacy for TMA, urges physicians to participate in the survey if they are contacted. She says the year 2000 survey is the latest in a biennial series allowing TMA to track trends in areas such as a continuing decline of physicians in solo practice, problems with patient access to care, and the extent of charity care and bad debt.

Data gained from previous surveys have been used to document the need for managed care reforms, to assist TMA in providing information to the US Department of Justice on the Aetna/Prudential merger, and to document third-party payer problems. The information also has been used in other legislative lobbying and payment advocacy efforts on behalf of physicians and patients. ★

POEP cancer education scholarships available

If you're a medical student wanting to attend a cancer education conference but find yourself short on cash, TMA's Physician Oncology Education Program (POEP) has the answer. POEP offers a limited number of scholarships of up to $500 each to reimburse you for travel and registration expenses.

More than 30 students took advantage of the program between August 1998 and this past August.

Scholarship applicants should be interested in primary care and be in good academic standing.

POEP can provide a list of approved programs, or you may apply to attend a program of your choice. Cancer prevention, screening, and early detection must comprise about half the conference. Conference coordinators interested in adding their programs to the POEP list of approved programs should submit a conference outline for review. Outlines can be submitted by fax at (512) 370-1693 or by e-mail at poep@texmed.org.

Scholarship applications are available at www.poep.org or from the POEP office staff.

For more information, call (800) 880-1300, ext 1672, or (512) 370-1672; or e-mail poep@texmed.org. ★

TMA WINTER CONFERENCE

Winter conference to explore keeping medicine relevant

Mark your calendars and make plans to attend the TMA Winter Conference February 26, 2000, at the Renaissance Austin Hotel. "Medicine's Relevance in the 21st Century" will be the conference theme.

Among the scheduled speakers is John A. Daly, PhD, Carter Professor of Communications and Management at The University of Texas at Austin.

Also scheduled are meetings of TMA committees, councils, and boards, and the TMA Strategic Planning Session.

For more information, call Amy Edwards at (800) 880-1300, ext 1346, or (512) 370-1346; or e-mail amy_e@texmed.org. ★

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Physician group to fine members for lengthy hospital stays

A physician group in Cambridge, Mass, has come up with a novel way to keep its patients from staying in the hospital too long. According to the *Boston Globe,* the 350-physician Mount Auburn Cambridge Independent Practice Association Inc has decided to fine its members $250 a day for each day of a patient's hospital stay that is deemed unnecessary.

According to an internal memo obtained by the *Globe*, hospital admissions will be examined by case managers to identify unnecessarily long hospital stays. Disputes between physicians and case managers will be decided by a committee of 12 doctors in the physician group.

Physicians in the group who oppose the policy say it is too punitive and could lead to denial of necessary medical care.

The Massachusetts Medical Society and the American Medical Association also oppose the policy. ★

TMA seeks nominees for science teaching award

January 31 is the deadline to submit nominations for the Excellence in Science Teaching Awards, established by the Texas Medical Association in 1990 to recognize Texas teachers who inspire future scientists and physicians and who promote scientific literacy and education.

Elementary, junior high, and high school science teachers are eligible. Each level provides a first place award of $1,000 and a merit award of $500. In addition, a $5,000 grant funded by Shell Oil Company Foundation will be awarded to each first place winner's school.

First place winners will be recognized during the opening session of the TMA House of Delegates at TexMed 2000 in San Antonio.

Winners are selected for their innovative approaches to teaching science, evidence of continued professional growth, and their reputation among their peers. County medical societies, TMA Alliance members, school principals, superintendents, and PTA/PTO presidents may nominate an eligible teacher for the award.

Nomination forms are available on the TMA Web site at www.texmed.org under "Health & Science" and by mail or fax. For more information, contact Jill Aslakson at (800) 880-1300, ext 1412, or (512) 370-1412; or e-mail jill_a@texmed.org. ★

Harris Methodist settles drug limits lawsuit

A $4.7 million settlement has been reached in a class action lawsuit by patients who sued the Fort Worth-based Harris Methodist Health Plan because it did not disclose the prescription limits it placed on physicians.

Critics claimed the spending limits imposed by Harris Methodist forced physicians to consider their own financial welfare before writing prescriptions. A Fort Worth physician group sued Harris Methodist over its prescription policy in 1997. (See "Cowtown Showdown," April 1998 *Texas Medicine,* pp 38–41.) The physicians accused Harris Methodist of violating a 1997 state law — which TMA was instrumental in passing — that prohibits financial arrangements that lead to the limiting of medically necessary care. A settlement, in which Harris Methodist agreed to increase physicians' pharmacy budgets, was reached in that case as well.

The *Dallas Morning News* reports the settlement is believed to be the first case where uninjured patients will recover money because their health maintenance organization (HMO) failed to disclose such incentives. Members of the health plan between October 1995 through May 1998 will be eligible to receive up to $50 each.

"Hopefully, this will keep other HMOs from misleading patients," George Parker Young, JD, the plaintiffs' attorney, told the *Morning News.*

Harris Methodist had no comment. ★

Benevolent fund helps physicians and families

Physicians, by training and inclination, help people in need. But what happens when the physician or his or her family needs help? That's where the Texas Medical Association's Physicians Benevolent Fund comes in.

The fund was established in 1961 with a $2,500 donation from the late May Owen, MD, a Fort Worth pathologist and past president of TMA. It assists destitute physicians and their families — both young and old — who are unable to work, and widows and dependents when they are left without adequate means of support.

The fund is managed by the TMA Board of Trustees, with guidance from the Joint Committee on Physicians Benevolent Fund of Texas Medical Association and Alliance.

The Physicians Benevolent Fund has provided more than $2.6 million in assistance to more than 500 physicians and their families.

"We would like to thank you for providing help to Mother when she really needed it. Thanks to your generosity, she was able to live her declining years with some pride and excellent care," a relative of a fund recipient wrote.

"The Texas Medical Association has been an angel to my dad," another testimonial said. "It is difficult to describe my heart to you — but it beats with love and eternal gratitude for the generous checks and consideration that is bestowed to my beloved dad."

The fund is financed through voluntary, tax-deductible donations from physicians and their spouses. Many contributors do so through memorial gifts and codicils in wills.

For more information about the fund, call (800) 880-1300, ext 1470, or (512) 370-1470; or e-mail sharon_g@texmed. org. ★

Aetna to physicians: we love you guys

Declaring that only a "vocal minority" of physicians are displeased with its actions, Aetna US Healthcare has created a unit dedicated to building relationships with the more than 250,000 physicians in its network. John T. Kelly, MD, PhD, will head the unit and report directly to company president Michael J. Cardillo.

"Dr Kelly's mission will be to create strong, effective, and lasting relationships with physicians based on mutual respect and a shared commitment to high-quality, affordable health care," Mr Cardillo said in a news release. "He will work closely with Aetna US Healthcare medical directors and participating physicians to enhance communications and identify ways to improve the effectiveness of our physician relations."

Among other things, the physician relations unit will act as a liaison to physician organizations and physician publications. The unit's initial focus will be to improve quality and enhance the use of technology within the company's network of participating physicians.

"The vast majority of our relationships with providers are positive, but there clearly has been a vocal minority of physicians who have concerns," said Arthur Leibowitz, MD, chief medical officer for Aetna. "It simply made sense to us to create a separate organization that does nothing but focus on provider relationships."

Dr Kelly, the former director of the AMA Office of Quality and Utilization Management, said Aetna is "committed to expanding our communication with physicians to see how we can address their concerns. We are also examining our processes to ease the administrative burden for physicians." ★

WHAT YOUR PATIENTS ARE READING

Dateline: Health

By Laura Albrecht

The following is a collection of current consumer magazine articles that feature health and medical information that your patients may read and ask you about. Send your suggestions and comments to Laura J. Albrecht, *Texas Medicine*, 401 W 15th St, Austin, TX 78701; or e-mail laura_a@texmed.org.

"LISA WAITS FOR A HEART." The editor's note on this special report on organ procurement and transplantation says it best: "By the time this day is over, 12 Americans waiting for organ transplants will die." *Life*, 11/99

"RELIEF FOR Rx BLUES." A step-by-step guide to drug stores online and down the street and comparisons on where to get the best deal for your drug buck are provided. *Consumer Reports*, 10/99

"LOG-ON A DAY KEEPS THE DOCTOR AWAY." An Internet service monitors the conditions of patients at home and delivers medical information to doctors via the Web. *US News & World Report*, 10/99

"THE SCARY NEW PARTY PILL." No calories and no hangovers, but it's deadly. Nearly 1.8 million women between the ages of 20 and 34 are using prescription drugs for recreational purposes. *Cosmopolitan*, 10/99

"I OWE MY LIFE TO CANCER." Lance Armstrong describes his life as a cancer survivor and how the deadly disease made him a different person. *Bicycling*, 11/99

"DOWN-THERE HEALTH SCARE. . . DOCTORS ELIMINATE YOUR EVERY BELOW-THE-BELT PANTY PANIC." Fibroids, AIDS, birth control, yeast infections, Pap smears, menstrual periods, and all those other things that scare female patients are explored. *Glamour*, 11/99

"FOLLOWING FLOYD." Elite teams of physicians deliver medical care and hope to victims who have lost everything in the North Carolina floods. *Life*, 11/99

"GOOD NEWS ABOUT BREAST CANCER." The survival odds are improving and patients are having their fears about breast cancer calmed. *Health*, 10/99

"HOW TO BEAT HEART DISEASE." Yes, even those hard-core runners face the risks of heart disease. *Runner's World*, 11/99

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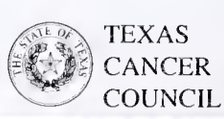

We're No. 1 in refinery pollution

Texas can claim another first, but you'd better forget those jokes about New Jersey. According to the Environmental Defense Fund (EDF), our 23 oil refineries emit the greatest quantities of toxic pollution per barrel of crude oil processed, while New Jersey refineries emit the lowest.

Close behind Texas refineries are those in Oklahoma, Montana, and Wyoming.

The EDF rankings are based on publicly reported data on sulfur compounds that create odors and cause acid rain, and volatile organic chemicals that contribute to the formation of smog.

The EDF state-by-state rankings are listed on its Web site at www.edf.org/communityguides. ★

TexMed 2000 to make Memorial Day memorable

Make your voice heard on important issues that affect you and your patients, and enjoy the many sights of San Antonio during the Memorial Day weekend at TexMed 2000.

The Texas Medical Association's annual meeting will be held at the Henry B. Gonzalez Convention Center and the Marriott Rivercenter Hotel May 25–28, 2000.

More than 200 hours of Category 1 continuing medical education will be available. In addition, you'll receive discounts on hotel rooms and tickets to theme parks.

Housing will be available at the Marriott Rivercenter, the Marriott Riverwalk, the Hilton Palacio Del Rio, and the Hilton Plaza. All room reservations must be made through the San Antonio Convention and Visitors Bureau's Housing Bureau.

Updated information will be provided on the TexMed 2000 Web site at virtual.texmed.org.

Check out San Antonio's Web site at www.sanantoniocvb.com, and start planning your trip to make this Memorial Day weekend one to remember. ★

SUMMARIES OF RECENT HEALTH CARE FINDINGS

In Case You Missed It

Researchers at The University of Texas Southwestern Medical Center at Dallas linked an antibody to a toxin, killing 99% of the human cells carrying a latent form of HIV-1. They targeted cells harboring latent HIV by using an immunotoxin formed by joining a monoclonal antibody made up of a protein from a single clone of cells and a subunit of a plant toxin, ricin. *Proceedings of the National Academy of Sciences,* 10/99

Contrary to conventional wisdom, the brain may generate new cells daily, say scientists at Princeton University. Their research on monkeys shows that thousands of new neurons show up in the cerebral cortex daily. *Science,* 10/15/99

Deaths from coronary artery disease appear to vary seasonally, peaking in December and January, a study of 220,000 death certificates in Los Angeles shows. *Circulation: Journal of the American Heart Association,* 10/12/99

Children may turn to smoking to lose weight, say researchers at Harvard's Brigham and Women's Hospital in Boston who studied 16,000 children between ages 9 and 14. Girls are twice as likely as boys to try smoking to lose weight. *Pediatrics,* 10/99

University of Tennessee and St Jude's Children's Hospital researchers predict that individually customized drugs based on a patient's individual genome may soon be available. They say the Human Genome Project, functional genomics, and new screening methods could lead to customized drugs. *Science,* 10/15/99

Symptoms of postural hypotension are exhibited in patients with carotid artery stenosis, according to a study by researchers in London of 46 patients between ages 58 and 81 with a history of transient ischemic attacks. *Journal of Neurology, Neurosurgery and Psychiatry,* 10/99

Two new studies at Harvard and the Christchurch School of Medicine in New Zealand show homosexual and bisexual men and women are at greater risk of suicide and other mental health problems than heterosexuals. *Archives of General Psychiatry,* 10/99

Cornell University researchers have successfully used the Sonic hedgehog gene to grow hair in mice. Next, they say, testing could be done on patients who have lost hair during chemotherapy treatment or on men with male-pattern baldness. *Journal of Clinical Investigation,* 10/99

SPEAK UP!

Need a speaker for your next medical meeting?

TMA Speakers' Bureau can help with a cadre of physician experts from across Texas. Topics cover a variety of issues, such as:

- recent legislative victories
- rural health
- physician workforce
- TMA activities
- CHIP

Contact the TMA Speaker's Bureau at (800) 880-1300, ext. 1375, or (512) 370-1375, or ken_o@texmed.org.

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TMA Foundation elects officers for 1999–2000

Beaumont neurosurgeon Mark J. Kubala, MD, a former TMA president, is the new president of the TMA Foundation for 1999–2000. He was elected during the TMA Fall Conference in September.

Other new officers are Emily Shelton, Lufkin, vice president; Beverlee Herd, Fort Worth, secretary; Greg Winegardner, Victoria, treasurer; and Bobby Q. Lanier, MD, Fort Worth, executive committee member-at-large.

Members of the TMA Foundation Board of Trustees are Drs Joseph A. Abell, Robert Bernstein, Max C. Butler, Harry K. Davis, Robert H. Emmick, Jr, Laurance N. Nickey, Ronald J. Pinkenburg, J. James Rohack, Paul H. Smith, Janet E. Squires, and Nalin H. Tolia; Robert G. Mickey; Barbara Lord Watkins; and Clarence H. Woliver. ★

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Texas Medical Association Physician Services

Med-mal math

Recent trends in medical malpractice liability are sending mixed signals

Regan Dunnick

Nineteen ninety-five's medical liability tort reforms were considered a victory for Texas physicians (see "The Art of Compromise," July 1995 *Texas Medicine,* pp 12–15). In fact, when you look at the substantial drop in claims against physicians from mid-1995 to the beginning of 1996, it's obvious the reforms led to an overall plaintiffs' retreat (see accompanying chart). But now, by some accounts, those numbers are once again on the rise. It could be just the upswing of the naturally cyclical course of medical liability insurance, or it could mean the beginning of a backlash. Either way, insurance carriers are battening down the hatches, which may mean an increase in your premiums. ➤➤

By Monica Maldonado, Associate editor

In Texas, current premiums are a by-product of the 1995 reforms, of which the main goal was to reduce the number of claims against Texas doctors. That effort worked. Figures from the Texas State Board of Medical Examiners (TSBME) show that the number of liability claims filed (referred to as "frequency") dropped 35% in 1996 and then another 12% in 1997.

But by 1998, those numbers began to creep up, a red flag to some medical malpractice insurance carriers that they may have to raise premiums. Carriers also worry about the seeming increase in the amount paid to settle or close claims (referred to as "severity"). Because so many cases are pending and the amounts paid per claim are difficult to monitor in the first place, looking at average dollar amounts year to year is not very useful, but the industry agrees that it costs more today to close a claim than it did 4 years ago.

Kenneth McDaniel, of the Texas Department of Insurance (TDI) Professional Liability Department, says that gauging the genesis and effect of claims filed now is difficult because the entire process, from initial investigation to settlement or award of damages, can take up to 5 years. But predictions can be made. Before any medical malpractice insurance carriers start reactionary premium pricing, though, Texas Medical Association staff members began talking to some of the larger companies about the need for an independent study of liability data to quantify changes in frequency and severity, and to identify ways to address these changes. If a problem exists, TMA also will begin looking at possible solutions.

Recent med-mal history

Two requirements of the 1995 tort reforms had a huge effect on the frequency and severity of medical malpractice claims. To reduce frivolous claims, the law allows judges to require plaintiffs to post a cost bond of $5,000 per defendant or to submit an expert's report outlining the merits of the case within 90 days of filing the suit. Previously, it was regular practice for the plaintiff's attorney to pay $2,000 per case and list every health care provider and physician involved with the patient/plaintiff, says Mike Hull, JD, an Austin defense lawyer who helped negotiate the bill for TMA. "The idea behind that legislation was to require that cases be reviewed early," he said, therefore weeding out the frivolous ones.

But even after the cost bond is posted, the law requires the plaintiff's attorney to file an expert witness report within 180 days. As a result, Mr Hull believes the quality of the lawsuits has gone up. Tommy Jacks, JD, an Austin attorney and a former president of the Texas Trial Lawyers Association (TTLA), agrees. "I get the sense that cases filed nowadays include more cases of merit," Mr Jacks said.

Bob Fields, executive vice president for claim operations at the Texas Medical Liability Trust (TMLT), disagrees. "The number of claims TMLT has closed without indemnity since tort reform has remained at about 85%, the same percentage as before 1995 tort reform."

Besides these requirements for plaintiffs, a factor that also may affect current insurance premiums is imposed rate reductions enacted by the legislature. Because lawmakers realized insurers could expect a drop in the overall cost of dealing with claims, TDI was ordered to make sure those savings would be passed on to the policyholders.

How the imposed rate reduction affects individual physicians' premiums varies, however, and some physicians may not notice a change at all. This fall, the commissioner of insurance announced that premiums would be 17% higher if not for the combination of the 1995 tort reforms and imposed rate reductions, an effect limited to policyholders with regulated carriers, which are subject to the reduction requirements. Mr McDaniel, of TDI, says physicians may not notice these savings because even without the pre-tort reform claims surge, premiums would have increased to adjust for inflation. "But the savings are there," he assures. The question is, how long will it be before premiums begin to creep up again?

Theories and explanations

Tom Cotten, president and chief executive officer of TMLT, which insures more than 42%, or 10,000, of TMA member physicians, says its data show across-the-board increases in claims, and not just in one type of practice. "To make matters worse, we're seeing the severity of these claims go up as well. Back in 1995, the average cost we paid to an injured client was $135,000. Currently, it's up to about $180,000," Mr Cotten said.

"We think this increase can be attributed to a failure of certain aspects of the 1995 tort reforms," he said. "For instance, we've found there are judges around the state waiving the cost bond requirement for plaintiffs, which the legislation left to judicial discretion." Mr Cotten believes this accounts for increased claims. "They're allowing some frivolous claims to be filed. What we're trying to do now is identify what other issues are leading to this increase."

But some disagree with TMLT's assessment. Mr Jacks, a plaintiff's attorney, says he hasn't noticed an unusual rise in claims, and adds it is smart to leave the plaintiff's cost bond and expert opinion requirement to the judge's discretion. "No one intended that to be a gotcha," he said. "You don't want a meritorious case being knocked out on a technicality."

Pending further study, TMA's Division of Medical Economics has its own hypothesis to explain the rise in liability claims against physicians. Part of

"What we have noticed is an increase in severity. The reforms seem to have eliminated some of the more frivolous cases."

Legal articles in *Texas Medicine* are intended to help physicians understand the law by providing legal information on selected topics. These articles are published with the understanding that TMA is not engaged in providing legal advice. When dealing with specific legal matters, readers should seek assistance from their attorneys.

the large increase can be explained by product liability cases. In the current fen-phen suit, the primary target has been the manufacturer. Harold Freeman, of TMA's legislative affairs staff, says he is not aware of any settlements or judgments against physicians. However, he says the insurance carriers of the physicians named in the suit will have to pay litigation costs.

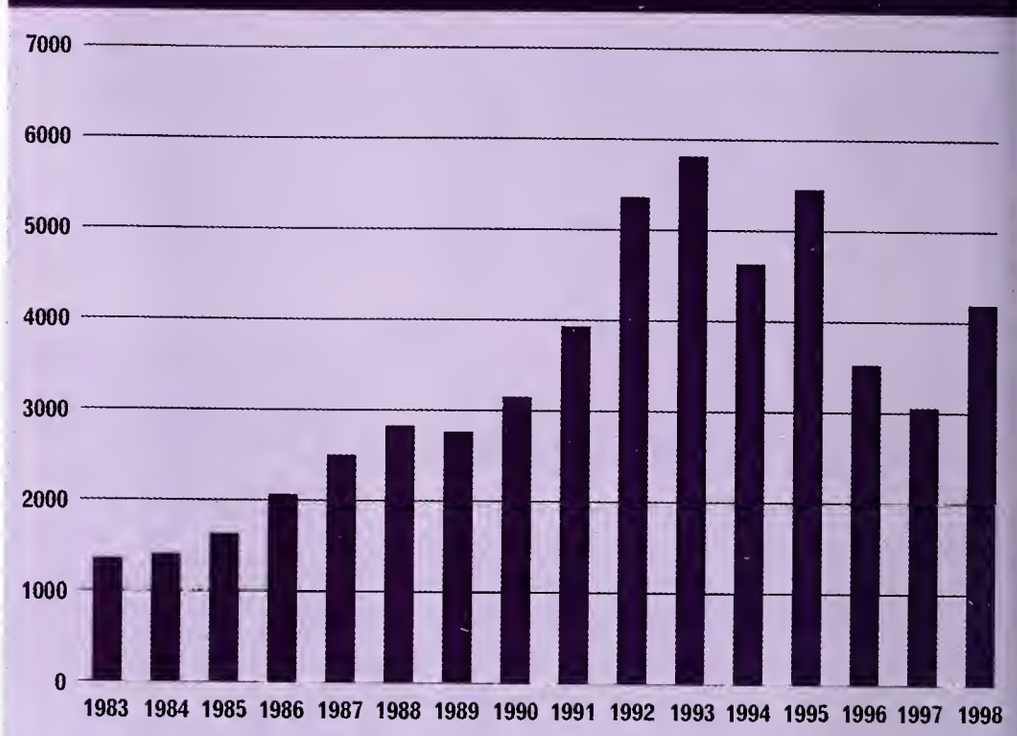
Another explanation might be the recent class action suit in the Rio Grande Valley against a hospital for representing that a cardiovascular surgeon was board certified when he was not. The surgeon has already been dismissed, but about 400 malpractice claims letters were sent to the physician and his partner. According to Mr Freeman, "There is some question as to the merit of the claims, and it may result in indemnity for the physicians. The carrier is obligated, however, to pay the defense costs." In the meantime, TMA leaders have met with Valley medical leadership to craft an aggressive response to what Kim Ross, TMA vice president for public policy, calls "egregious lawsuit abuse."

TMA staff members also are looking at the occurrence of trial judges waiving the cost bond and expert opinion requirements. A preliminary analysis by TMA shows that out of the 54 cases handled by one of TMLT's primary defense attorneys, the judge waived the cost bond or expert opinion requirement in only 3. As for severity of claims, Mr Freeman says TMA hopes the proposed data study will reveal the extent of the increase and the causes.

Mutual Assurance, a carrier based in Birmingham, Ala, also hasn't noticed a rise in frequency but says this may be because it just entered the Texas market about the time the reforms were adopted. "What we have noticed is an increase in severity," says Frank O'Neil, vice president of corporate communications. "The reforms seem to have eliminated some of the more frivolous cases."

Mr Hull, a defense attorney, says that was exactly the intent of the provision for an expert's report and that by pushing for this tort reform legislation, physicians may have somewhat shot themselves in the foot. "By requiring plaintiffs to file an expert's report, it has made their cases better," said Mr Hull. "The risk for defendants is higher, and from the defense perspective, it takes what used to be one of our strongest arguments away from us: the qualifications of the plaintiff's expert weren't up to par with our defendant's."

Malpractice claims reported



Source: All data derived from Texas State Board of Medical Examiners database or reports (data used are highest reported numbers).

How this affects your premiums

Is there a premium hike on the horizon? Because data reflecting the frequency and severity of claims are somewhat open to interpretation, the method for setting premiums is complicated. The way TDI's Mr McDaniel described it, carriers adjust their premiums similar to the way sea captains stay on course without navigation instruments: "They look behind them to see where they've been, and set a course based on keeping their wake straight." Each carrier will look at various statistics on frequency and severity of claims, and predict a range of premiums. If the carrier is regulated (or sometimes even if it is not), it files its rate changes with TDI, which then reviews the submitted data and determines whether its rate changes are justified.

Because premiums are based on losses anticipated by medical malpractice insurance carriers, sometimes rates can be off the mark. Add increasing competition among insurance carriers, according to Mr McDaniel, and you've got pricing dilemmas. As Mr O'Neil of Mutual Assurance says, Texas is a huge medical market, "and everybody wants a piece of it.

"So you have a number of companies that are chasing top-line growth, trying to build market share by charging low, unsustainable premiums," he explained. To maintain a piece of the market over the long term, he says, carriers must consider what is happening in the liability climate. "I think we're going to have to deal with this increase in severity, and our premiums will reflect that," he says. "Eventually, companies will have to raise rates or go broke. It's just a question of how much pain any one company can stand." ★

Monica Maldonado can be reached at (800) 880-1300, ext 1385, or (512) 370-1385; or by e-mail at monica_m@texmed.org.

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Patient and physician share a touch and smile. Pediatric oncologist Lawrence S. Frankel, MD, makes life easier for 3-year old Colton O'Neal, of Kosse, Tex. Dr Frankel is director of the Pediatric Hematology/Oncology Division at Scott & White in Temple.

Photography by Susan Gaetz
Text by Laura Albrecht, Photo editor ➤

“The treatment of a disease may be entirely impersonal; the care of a patient must be completely personal.”
Francis Weld Peabody

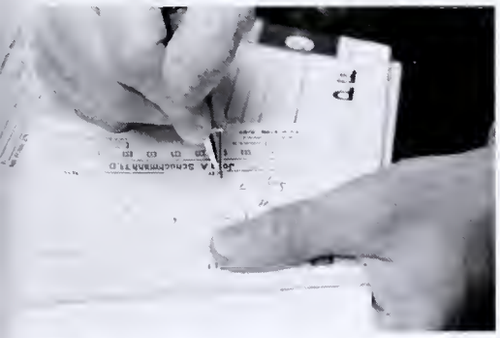
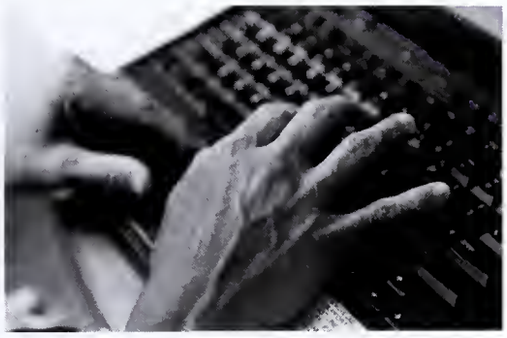
Robyn Young, MD

“It is our duty to remember at all times and anew that medicine is not only a science, but also the art of letting our own individuality interact with the individuality of the patient.”
Albert Schweitzer

Clint A. Long, MD

“Observation. Reason.
Human understanding. Courage.
Those make the physician.”
Martin H. Fischer

Daily actions in a physician's life. Educating, prescribing, dictating, examining, consulting, listening, learning, and healing.

“The first duty of the doctor is in all cases and all circumstances to respect the personality of the patient who places himself in his hands.”
Robert de Vernejoul

Jeana O'Brien, MD

“Healing is a matter of time, but it is sometimes also a matter of opportunity.”
Hippocrates

John Schuchmann, MD

“Surgery, after all, is an affair of the spirit; it is a fierce test of a man’s technical skill, sometimes, but, in a grim or long fight, it is above all a trial of the spirit; and there are few things that cannot be conquered if a man’s heart is set on victory.”
Sir Berkeley Moynihan

Scrub in and glove up. Orthopedic surgeon Rick Schultz, MD, readies for a day of surgery.

“A skilled physician can revive the springtime of life.” Chinese proverb

Playing is healing, and a good dose of laughter and fun brings out the best in us all. Pediatrician James H. Brien, MD, reacts with joy while playing a game with a patient in the Child Life Pediatric Playroom.

“It is the human touch after all that counts for most in our relation with our patients.”
Robert Tuttle Morris

With the touch of many. Hayden Berry Jackson is welcomed into a new world by Berry and Stephanie Jackson, along with obstetrics-gynecology chief resident Mike Lamar, MD.

Gentle touches for little patient. Neonatologist Charles Oltorf, MD, examines Dallas Nicholle Williams, of Dallas.

“Once in a while you will have a patient of sense, born with the gift of observation, from whom you may learn something.”
Oliver Wendell Holmes

Wake-up call

Could California's medical group insolvency crisis happen in Texas?

The core of California's managed health care system — and the physicians, health plans, and patients who comprise it — are in jeopardy. With the recent bankruptcies of FPA and MedPartners, could Texas be far behind? The Lone Star State's physicians and health plans are keeping watch on California and working to protect Texans from this epidemic. ➤➤

By Johanna Franke, Associate editor

West Coast woes

An estimated 90% of California's physician organizations are poised for bankruptcy, according to a September 2 report commissioned by the California Medical Association (CMA) from PricewaterhouseCoopers. The state's physician practice management companies (PPMCs), medical groups, and independent practice associations (IPAs) face a financial crisis that has led to more than 100 bankruptcies since 1996. The report projects that at least 34 medical groups or independent practice organizations will close or go bankrupt before the end of 1999, up from 31 in 1998.

When California's two largest groups — FPA Medical Management, Inc, and MedPartners Provider Network — went out of business this year, they potentially disrupted care for nearly 2 million patients and left physicians and hospitals more than $300 million in debt.

The domino effect leading up to these failures began with California's employers' demands for low-cost health care, which ignited a fierce competition among the state's health plans and drove premiums down to the lowest rate in the country, says Elizabeth McNeil, CMA's vice president for medical policy and economics. "It is painfully clear here that the for-profit health plan is more responsible to Wall Street than to health care," Ms McNeil said. "California's premiums are 23% below the national average and 40% below the premiums of northeast states that we consider to have similar costs of living. We're at $135 and Massachusetts is at $185 per month."

Physicians and patients alike face limited participation choices as California's health plans have merged to increase their market power. The 16 plans that existed 6 years ago in the state have given way to 6 large plans that control more than 90% of the market. With both purchasers and health plans consolidating, California physicians felt they had to follow suit and form large groups to generate negotiating power with the plans. These groups are now taking a beating.

Despite uniting for more clout with the plans, California physicians found they had little control over plummeting capitation rates, Ms McNeil says. "We have what you would call predatory pricing," she said. "You have an oversupply of physicians, and you have very powerful plans, and there's no negotiation that takes place between the plans and the medical groups. It's take-it-or-leave-it contracts and take-it-or-leave-it rates, and these rates are based on whatever the market will bear. If one medical group or IPA says, 'No,' there's another one down the street that's desperate enough to say, 'Yes, we'll take it.'"

When California's two largest groups went out of business this year, they potentially disrupted care for nearly 2 million patients and left physicians and hospitals more than $300 million in debt.

The amount of money paid by health plans to physician groups to take care of patients dropped from a high of $45 per patient each month in the period from 1990 to 1993 to a low of $29 from 1997 to 1999, according to the PricewaterhouseCoopers report. Though state regulations require licensed health plan rates to be certified by an actuary, these laws often are not enforced. "Very few health plans in California have actuaries," Ms McNeil said. "If they do, the rate they end up offering doesn't really look like an actuarial rate."

The next set of dominoes fell at the feet of medical groups, which had to deal with delegated administrative costs and lack of information from health plans as well as the responsibility for managing the costs of prescription drugs in managed care systems.

Health plans in California take an average 15.2% of the premium dollar for overhead and profit, according to the latest CMA Knox-Keene Health Plan Medical Loss Ratio report. California's Knox-Keene Act regulates the financial stability of health plans but does not regulate medical groups or other physician organizations, nor does the act dictate solvency requirements for the state's medical groups or IPAs.

The health plans' percentage has not decreased as they have delegated more administrative duties such as utilization review, quality assurance, and claims processing, to the medical groups. Some California IPAs spend as much as 30% of the physician portion of their capitation payment for administration. "In the MedPartners' model, we calculated 40% coming off the top of the premium dollar for administrative costs," Ms McNeil said. "You don't have much more for patient care right there."

The CMA report also states that health plans, as contracting partners with physician groups, have not been accountable to the groups for the timely provision of basic information. To assess their financial positions, physician groups need data such as utilization information on risk pools, regular reports for coordination of benefits receivables, third-party recovery receivables, retroactive additions and deletions in enrollment, changes in benefits, and pharmacy rebates.

Some physician groups sank deeper when they accepted pharmacy risk, despite their lack of control over prescription drug prices. "We've had double-digit inflation for pharmacy costs over the past several years, and with direct consumer advertising and the FDA [Food and Drug Administration] approving all these consumer drugs on a faster track, you've got high expenses on the pharmacy side," Ms McNeil said.

After the demise of these groups, the final dominoes to fall were the physicians and, ultimately, their patients, for whom California doctors are reaching into their own pockets to cover the cost of care. California physicians are scrambling to find other IPAs to pick them up so they can keep their patients, Ms McNeil says. They're also retiring early or leaving California altogether. "And we can't attract young

physicians to California anymore because of the cost of living and low salaries," Ms McNeil said.

CMA's solutions for this crisis are built into proposed state legislation requiring actuarially sound capitation rates, prohibiting downside pharmacy risk for medical groups, establishing administrative cost limits, requiring health plans to submit timely financial information to medical groups, and ensuring that medical groups meet financial monitoring standards. CMA also supports US Rep Tom Campbell's (R-Calif) bill, HR 1304, which amends federal antitrust laws to allow physicians in larger groups to negotiate with health plans.

Texas takes note

Ask Texas medical solvency experts if they expect the state's medical groups and IPAs to start dropping like flies, and they answer warily that it could happen, but it probably won't — certainly not the way it's happening in California.

"California was first in the managed care arena, so we have the benefit of seeing what its life cycle has been," said Spencer Berthelsen, MD, medical director for managed care at Kelsey-Seybold Medical Group in Houston. Kelsey-Seybold, a 50-year-old integrated group that has been involved in managed care for 17 years, has about 300 physicians in 25 locations.

At this point in California's life cycle, the state's managed care market has 19 million patients, compared with Texas' 4 million.

"We, too, looked at California, and we think it can happen in Texas. But this is one of the areas that the health plan association and the medical association can and will and want to work together to try and fix."

The "California mentality" already has leaked into Texas in the form of now defunct PPMCs like FPA and MedPartners, says Arlington general surgeon Bohn Allen, MD, former chair of Texas Medical Association's Council on Socioeconomics and member of the TMA Board of Trustees. "They had physicians squeezed down to where they could not sustain their practices on the reimbursement they were getting."

But many Texas physicians have learned from the experiences of their West Coast colleagues. Without the intense competition among plans that dictates California's managed care system, Texas physicians have the luxury of being careful when signing on with groups and taking risks, especially concerning capitation. Texas physicians, through TMA, also have worked to inoculate themselves against California's epidemic with groundbreaking legislation such as this year's Senate Bill 1468, which allows independent physicians to jointly negotiate contract terms with managed care plans (see "TMA at the Table," November 1999 *Texas Medicine*, pp 28–32).

Another piece of 1999 legislation, Senate Bill 890, is the first attempt to set minimum standards for physician- or provider-led networks. Inspired by a white paper drafted by TMA's Ad Hoc Committee on Physician Directed Networks, the bill establishes standards by which physician networks perform health maintenance organization (HMO) functions by delegated authority.

As of September 1, the bill required networks to hold a third-party administrator license if paying claims and a utilization review license if conducting utilization review activities. SB 890 also specifies the information that networks need to provide health plans, such as the number of claims paid and claims outstanding.

"These are just basic financial reporting requirements from which the HMO, when looking at these reports, will be able to detect a medical group that is struggling and ask for a corrective action plan," said Dr Berthelsen, who chairs the Ad Hoc Committee on Physician Directed Networks. About 30 physicians representing IPAs and group practices of all types — large and small, urban and rural, and multispecialty and single specialty — serve on the committee. If the corrective action plan is not forthcoming or adequate, then the HMO can call upon the Texas Department of Insurance (TDI) to review the information in detail and limit enrollment to the group or redirect patients away from the group, he adds.

Lastly, SB 890 requires heath plans to report to the group data that the group needs to manage its financial affairs, such as detailed eligibility information. The bill, which was fashioned with the help of the Texas Association

TMA Advantage
Reaching out to groups

As Texas physician groups continue to evolve, Texas Medical Association leaders want to be sure TMA is meeting these groups' advocacy and service needs. To do so, TMA's Office of Planning and Development created a large group outreach program nearly 2 years ago to open up communication among Texas groups, county medical societies, and TMA.

Through the program, TMA staff members travel to different parts of the state to inform group physicians and administrators about TMA services that can assist them in their practices. Staff members also seek to identify physicians who want to get more involved in organized medicine.

For more information, call Bridget Horton, director of TMA's Office of Planning and Development, at (800) 880-1300, ext 1404, or (512) 370-1404; or e-mail bridget_h@texmed.org.

of Health Plans (TAHP) and some consumer groups, does not apply to individual physicians or integrated groups that contract out for less than 20% of total revenues for care.

The ad hoc committee's efforts legally clarify TDI rules already in place that require health plans to pay for costs when a contracting network becomes insolvent, but "when it's put into law, it carries weight. That's for sure," said Betty Patterson, senior associate commissioner for TDI's financial program. The bill "goes a long way to detail some of the specific requirements and TDI's ability to step in."

TMA's ad hoc committee members will monitor the effects of the bill, which they hope to extend past September 2001, when SB 890 will be sunsetted at the request of TAHP. Jerry Patterson, TAHP's executive director, says the health plan association insisted the bill be sunsetted because "we want to put some impetus to go back in the next session and address the financial aspects of risk assumption for downstream providers, which were not addressed in the bill."

Mr Patterson also has his eye on the West Coast. "We, too, looked at California, and we think it can happen in Texas," Mr Patterson said. "But this is one of the areas that the health plan association and the medical association can and will and want to work together to try and fix."

TDI's Ms Patterson praised Texas health plans' quick response to prevent discontinued care for patients during contracting network failures, such as the FPA bankruptcy.

Mr Patterson said, "I think some physicians don't think much about HMOs, but in the case of FPA, we had a herculean effort by plans to make sure the physicians were paid, and the plans continued to do that, at great expense, until the bankruptcy court made them quit doing it."

Group effort

Health plans aren't the only ones to blame for California's situation, Ms McNeil says. "Clearly, some groups are mismanaged. You can't just say this whole thing is because they're not getting enough money. Medical groups have got to do a better job tracking the dollars and being better businesspeople."

TMA Advantage
Is your physician practice management company healthy?

In light of the problems and financial difficulties plaguing physician practice management companies (PPMCs), physicians who have contracted with such organizations should know the risks they could face.

To determine if your practice management company is experiencing serious operational and/or financial problems, ask yourself the following questions devised by Texas Medical Association Physician Services. Too many "no" answers could indicate possible trouble.

- Are your independent practice association claims being paid?
- If you are employed by the PPMC, are you being paid consistent amounts in an appropriate amount of time?
- Are you receiving your capitation payments in a timely manner?
- Are changes to contracts communicated in a reasonable amount of time?
- Are changes to contracts communicated at all?
- Are office and/or business policies and procedures in place? Are they comprehensive? Are they made available to you?
- Is the company responsive when problems or issues are presented to it?
- Does the company answer your questions in a timely manner?
- Does the company provide the services it is contractually obligated to provide?
- Does the company provide you with adequate management reports and/or data?
- Has the company increased office efficiencies?
- Has the company improved the reimbursement rates in your managed care contracts?
- Are your accounts receivables paid within 60 to 90 days?
- Does Dun & Bradstreet (www.dnb.com) or any other similar company that provides financial data on organizations have positive information to report on the company?

If you believe your practice management company could be facing financial and/or operational difficulties, TMA offers a wide array of resources to help you, such as:

- Intervention with major private and public sector payers to resolve individual physicians' payment problems;
- Consultations on coding, billing, reimbursement, denial of services, and filing of claims;
- Reduced rates for contract evaluation services performed by a law firm in Austin for legal pitfalls in new or existing contracts;
- Educational brochures about signing managed care contracts, selling a practice, choosing a management services organization, and other topics;
- Consultations on developing a managed care strategy;
- Access to managed care administrative services such as credentialing, utilization review, and provider-specific stop-loss coverage; and
- Practice management consultants with many areas of expertise.

Whether you have questions about billing or coding or would like consulting services, TMA Physician Services can direct you to the appropriate person or TMA department. Call TMA Physician Services at (800) 523-8776; e-mail physician_services@texmed.org; or visit TMA's Web site at www.texmed.org.

One of Texas' group success stories is COR Specialty Associates of North Texas (CSANT), the state's largest medical and surgical group practice providing cardiology, cardiothoracic surgery, pulmonology, vascular surgery, and heart and lung transplantation services. The 18-year-old group, which has 50 members and more than 20 medical offices in the Dallas-Fort Worth area, has a simple secret to its success.

"We avoid schemes," said Stephen Arnold, director of marketing and managed care at CSANT. By that, Mr Arnold means his group has not gotten involved with any practice management groups and does not take pharmacy, hospital, or capitation risks, he says.

When Mr Arnold joined CSANT in 1994, the market was rushing toward capitation and the development of practice management companies, IPAs, and management services organizations. "We just could not understand

TMA Advantage
Shopping for strong, stable IPAs

With the passage of Senate Bill 1468, which allows physicians to collectively negotiate with payers under certain circumstances, physicians are examining their options for joining groups. One option is the independent practice association (IPA) model, which may be structured as a professional association, a professional limited liability corporation, a nonprofit corporation, a partnership, or a nonprofit health care corporation, which also is known as a 5.01(a). IPAs typically contract with health plans to provide services to the plan's patient population either through a capitated arrangement or a fee-for-service basis.

According to Texas Medical Association Physician Services, strong and stable IPAs need to exhibit the following characteristics:

GENERAL

Clearly articulated mission, vision, and goals: The primary mission should be consistent with improving the practice of medicine, enhancing the delivery of services, and maintaining a position in the market. Members should share and understand the IPA's vision and long-term goals so that member expectations can be managed effectively. The IPA should have a thoughtful and realistic written business plan that is viewed as a dynamic process and updated throughout the organization's life.

Effective leadership and strong governance: The IPA should have a core group of physician leaders who are committed to putting the IPA's welfare first and willing to represent *all* members without being swayed by more vocal participants. Key questions to ask about the IPA leadership include:

- Are the leaders experienced in managed care?
- Do the leaders have experience in leading groups and building consensus?
- Do the leaders demonstrate their commitment to the IPA through the investment of time and energy?
- Do the leaders allow membership participation in decision-making; are they willing to make tough decisions and able to say no to a minority?
- Are the clinical practices and expertise of the leaders respected by other physicians?
- Are the leaders flexible and able to adapt quickly to the rapidly changing health care environment?
- Are the leaders able and willing to refuse contracts that do not benefit the IPA as a whole?
- Do the leaders of the various committees (utilization and quality management, credentialing, finance, contracting, etc) have relevant experience?

Quality standards: The IPA should have credentialing standards consistent with the National Committee for Quality Assurance and be willing to educate or mentor those members who are not operating as effectively as possible or who are unwilling to participate in developing or practicing agreed-upon clinical protocols.

Membership: An IPA may be experiencing trouble when signs of erosion of membership arise. Are other physicians seeking entry into the IPA? Are existing members being retained? Are competing IPAs being formed? Is there collegiality between primary care physicians and specialists? Is the IPA board representative of its members? Have referral guidelines and revenue-sharing arrangements been developed jointly? How much time is spent trying to resolve these issues?

Communication: IPAs should use a variety of informal and formal methods to compensate for different communication preferences, such as quarterly newsletters, regular meetings, and e-mail.

LEGAL

Advisors: The IPA should have competent legal advisors experienced in health care who draft and/or review organizational documents, assist with legal structure, and provide ongoing advice as needed.

Documents: The IPA should have a number of legal documents, some of which include the articles of incorporation, bylaws or regulations, stock and/or partnership agreements, description of organizational structure, participating provider agreements, policies and procedures for contracting, and credentialing applications.

Insurance: The IPA should have general liability insurance, directors and officers (D&O) coverage, and errors and omission (E&O) protection. Experts recommend that the E&O coverage includes claims related to antitrust and managed care liability.

why all of this was going on," Mr Arnold said. "In my mind, capitation is 80s technology. It's not where the business should be."

Dr Allen agrees. "Nearly everybody is abandoning capitated contracts or risk contracts," he said. "They're all trying to go back to some kind of fee schedule or reduced fee-for-service schedule because they can lock in a reimbursement they can at least work with."

And Dr Allen believes IPAs aren't where the business should be, either, and he predicts more IPA failures in Texas. "It turns out IPAs have not been the answer for doctors because they can't negotiate fees," he said. "They're hamstrung by the Federal Trade Commission, and they're really not all that efficient because their members are not all committed to one goal."

Peggy Pringle, director of TMA Physician Services, says she has seen a lot of physicians leaving IPAs and large groups

Managed care contracting: The IPA's legal advisors should be experienced in reviewing and negotiating agreements with payers and be cognizant of the specific provisions that will be beneficial to the IPA.

OPERATIONAL

Staff: Management of a large IPA is a full-time job that requires a professional who has experience in managed care contracting, financial monitoring and planning, and physician practice operations. If the medical director is unable to devote the necessary time, a utilization review nurse may be needed to provide case management, monitor utilization patterns, and support the activities of the utilization/quality management committee. The staff should be empowered to make appropriate decisions about the day-to-day operations of the IPA, guided by the policies that have been developed by the leadership. A high staff turnover rate may be indicative of a deeper problem with the structure or management of the IPA, although this may also be a sign of a tight job market. Additionally, the IPA should be willing to pay for other professional advice and consulting on an as-needed basis.

Infrastructure: An information system that is capable of providing relevant data and the expertise to understand and apply that data is absolutely essential in supporting any assertions the IPA makes to payers about volume of service, population characteristics, and quality of service. Being able to corroborate these claims with hard data will strengthen the IPA's negotiating clout with payers. Other evidence of a strong infrastructure includes the capacity to perform or have access to other administrative services, such as contracting, claims processing, utilization management, quality improvement, and credentialing. Comprehensive reports should be reviewed by the IPA leadership on a regular basis.

MARKETING

Characteristics: To appear attractive to payers, IPAs should possess the following attributes and use them in their marketing efforts:

- Wide geographic accessibility;
- A range of physician specialties that can address a continuum of care;
- Availability of physicians who appeal to a diverse population;
- A proactive quality-improvement program;
- Privileges at facilities that are recognized and well regarded in the community; and
- Ability to perform delegated functions.

Strategy: The IPA should outline specific action steps to reach a target market that has been thoroughly researched and identified. The IPA may want to contact employers in the community to explore the possibilities of direct contracting.

Distinction: A strong IPA will find ways to distinguish itself from other organizations, whether it is through community activities, responsiveness to patient complaints and suggestions, preventive services, or after-hours care.

FINANCIAL

Reserves: If the IPA is paying claims, cash reserves equaling a minimum of 3 months' worth of "incurred but not reported" claims should be available. A year's worth of operational expenses is even better. The IPA should have stop-loss insurance if it is participating in capitated contracts.

Contracts: One or two payers should not account for the majority of the IPA's income. Diversification of payers will provide some protection should a dominant payer terminate a contract.

Risk-sharing: An IPA's methodology for determining the risk-sharing process should be well understood, and the rates should be realistic.

Dues: The IPA should request reasonable and realistic dues. Funds are needed for the initial capitalization of an IPA, but ongoing operational expenses must be covered as well.

For more information on IPAs, call TMA Physician Services at (800) 523-8776; e-mail physician_services@texmed.org; or visit TMA's Web site at www.texmed.org.

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that are unprofitable. They often call TMA Physician Services to help with practice start-up issues. "Physicians want to get back into private practice. IPAs sound good on paper, but when it comes down to it, physicians need to be in charge of their own businesses and have a vested interest," Ms Pringle said.

But Mr Arnold says being members of a 50-physician group helped CSANT physicians weather the Genesis storm. "We lost about $150,000 on that deal, but our group was large enough that we could afford to do that, which is part of the value of the group," he said.

A Dallas 5.01(a) entity, Genesis Physicians Practice Association filed for bankruptcy in July after weeks of analysis of claims payment and insurance company reimbursement problems. The bankruptcy affected seven HMO risk contracts covering about 30,000 patients.

"I think most of the groups in trouble out there are the ones that are taking the multispecialty capitation and then trying to pay for services that they don't provide internally," Mr Arnold added. "That's the Genesis position and it doesn't work."

Sharing concerns with similar groups also contributes to CSANT's success. By working closely with the Dallas County Medical Society, Mr Arnold has been able to discuss market trends and learn "how to influence rational behavior" with other group leaders in North Texas. TMA also is keeping in touch with groups through county medical societies with its large group outreach programs (see "Reaching Out to Groups," p 52).

Though communication among groups is important, the bottom line for most solvency issues is the bottom line, and Texas physicians can take charge of it, Dr Allen says.

"Realistically, certainly in Texas, where there's the prohibition against the corporate practice of medicine, health plans can't practice medicine," he said. "The plans have to have physicians. And if physicians just wake up and inform themselves, they'll figure out that if they're losing money on every transaction, they can't make up for it by volume and they've got to set a threshold. If they're offered a contract that's below that threshold, they simply need to say no. I think if physicians do that, they'll force the payers to come back and renegotiate with them." ★

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Lawmakers, regulators to take hard look at Internet access to health care

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Drugstore.com, drkoop.com, Rx.com, WebMD.com. The list seems endless. A virtual explosion of health-related sites on the World Wide Web has made health and medicine one of the most popular topics on the Internet. Some estimates place the number of health-related Web sites at more than 25,000, including several hundred sites where Web browsers can buy drugs, contact lenses, durable medical equipment, and even health insurance with just a few clicks of the mouse. Or they can learn the latest developments on a host of diseases or new medical treatments. ➤➤

By Ken Ortolon, Associate editor

While the rapid increase in access to medical information via the Internet is seen as positive by many, concern has arisen among organized medicine and government regulators over just who is dispensing these drugs, how reliable the medical information is, and what the motives of the site sponsors are. That concern soon could draw the attention of the Texas Legislature.

State Rep Patricia Gray (D-Galveston), chair of the House Committee on Public Health, has recommended to House Speaker Pete Laney (D-Hale Center) that he authorize her committee to study Internet health issues during the legislative interim and report its findings to the 77th Legislature in 2001.

Grasping the problem

Representative Gray specifically recommended that the Public Health Committee be charged with studying the rising use of different technologies in the delivery of health care and its impact on the health status of Texans. Specifically, the committee would be asked to:

- Identify the risks and opportunities associated with the sale of durable medical equipment, contact lenses, and drugs through the Internet;
- Review regulations affecting physicians and other health care professionals with respect to emerging medical technologies, including the Internet;
- Evaluate the feasibility, quality, and cost-effectiveness of expanding telemedicine to improve access to health care in medically underserved and rural areas; and
- Identify patient and physician acceptance of different technology applications and what impact the increasing use of technology has on patient privacy.

At press time, Speaker Laney had not yet issued his charge for interim legislative studies but the Public Health Committee staff had begun its initial research on the issue in anticipation of the charge. Representative Gray, who has had a longstanding interest in telemedicine issues, says she is particularly interested in looking at the sale of drugs and durable medical goods via the Internet, as well as Internet marketing practices and the reliability of medical information on the Web.

"The question we must ask is, how do we ensure that it is quality information with a scientific base so that people have some assurance that they can rely on the information?" she said.

State medical boards in Texas and across the nation, as well as the American Medical Association, other health care organizations, and even some of those entities that are providing health care information and services on the Web already are grappling with that question.

"What we have to recognize is that the Internet is going to be used in the practice of medicine, that there will be innovative ways to use it, and that many of those ways will improve the quality of care," said James Winn, MD, executive vice president of the Fort Worth-based Federation of State Medical Boards. "What we want to do, though, is set up appropriate use where patients aren't placed in harm's way by entrepreneurism."

Bruce Levy, MD, JD, executive director of the Texas State Board of Medical Examiners (TSBME), says Internet medicine can be a great tool to help people make rational decisions about health care, if it is used accurately.

Dallas ophthalmologist Robert M. Tenery, Jr, MD, a member of the AMA Council on Ethical and Judicial Affairs, says efforts to protect patients must focus on preventing the violation of medical practice acts or other laws through the dispensing of drugs or medical advice across state borders. They also should focus, he says, on monitoring the validity of scientific information to assure its accuracy and appropriateness, and ensuring full disclosure of any conflicts of interest, particularly financial conflicts, that sponsors of health-related Web sites might have.

> "What we have to recognize is that the Internet is going to be used in the practice of medicine, that there will be innovative ways to use it, and that many of those ways will improve the quality of care."

Filling the prescription

The issue that has galvanized concern about Internet medicine is online prescribing. Many prescription drugs are available through the Internet but the one that appears to be the most widely sought at the moment is Viagra, Pfizer's popular new drug for impotence.

Public Health Committee staff members say that in their initial research, they logged on to the Internet, punched up a site selling Viagra, and could have had it sent to their office merely by filling out a questionnaire, with no further questions asked. A sample of such a questionnaire was included in an AMA Board of Trustees report on Internet prescribing. It simply asked consumers to list any known allergies, current medical treatment they were receiving, current medications they were taking, whether any of those medications are classified as nitrates, whether they had trouble achieving an erection, and whether they suffered one of several types of heart conditions. The AMA report warns that the terminology used to describe those conditions may be beyond the level of understanding of most consumers.

Dr Winn says the federation has seen examples where the answers to the questionnaire clearly placed doubt on whether Viagra should be prescribed, but the drugs were sent out anyway.

Representative Gray says this type of situation is particularly troubling for lawmakers interested in protecting patients. "There's no medical procedure and no drug or device that is 100% safe 100% of the time for 100% of the population," she

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said. "That's why we need to be very skeptical about quality control and whether people are getting what they really need."

Dr Levy says traditional online pharmacies, which require consumers to obtain proper prescriptions from physicians who have conducted history and physical examinations, are a legal and acceptable means of obtaining prescription drugs. Sites that prescribe drugs with no pretense of a prescription are blatantly illegal. But the use of the medical questionnaire presents a "gray area," he said.

"When we look at proper prescribing, the board has always taken the stance that a history and physical examination is required, that the physician must establish the identity of the patient, and that the physician must be available at any time for patient questions," Dr Levy said. "Just filling out a questionnaire would be inadequate."

While Dr Levy believes TSBME has the legal authority now to take action against any Texas physician prescribing under those circumstances, he says a law clearly making it illegal to practice medicine on the Internet without physically examining patients would give the board greater clout.

Who's minding the store?

Unfortunately, it's not just a matter of calling the guilty party on the carpet. Dr Winn says the greatest problem medical boards face in trying to stop this type of prescribing is identifying who the physician is and in what state he or she is licensed. Frequently, it is difficult to determine who is operating a specific site and whether the person reviewing the questionnaires even has a license to practice medicine. Plus, many such Web sites are based in foreign countries, meaning state and federal regulators have no way to stop them without international cooperation.

Another problem is the drugs themselves. Often they are counterfeit, adulterated, or black-market drugs, Dr Winn says. Even the manufacturers have asked federal authorities to crack down on sites distributing their products.

Some state boards have taken action against physicians prescribing online. Dr Levy says Kansas has disciplined a physician who was prescribing drugs without holding a Kansas medical license. Washington State also has disciplined one of its licensees for not establishing an adequate diagnosis through a history and physical exam. Illinois prosecutors recently filed four lawsuits against out-of-state doctors, pharmacies, and Internet-based companies that they claim were not licensed to operate in Illinois and failed to disclose that fact to consumers.

> "If an activity is prohibited in the physical world but not on the Internet, then the Internet becomes a safe haven for criminal activity."

Dr Levy would not disclose whether TSBME has any ongoing investigations in this area. He did say that the board has asked TSBME staff to submit recommendations on dealing with Internet prescribing. Those recommendations likely will be reviewed and possibly adopted at the board's meeting this month.

Meanwhile, Dr Winn says the Federation of State Medical Boards is working on strategies to help state medical boards identify and act against physicians who prescribe inappropriately. The federation's Special Committee on Professional Conduct and Ethics is working on language that states can place in their medical practice acts to deal with these situations.

"Basically, what they're likely to say is that except in an emergency it is going to be unprofessional conduct for a physician to provide treatment recommendations, including issuing a prescription, through any means — electronic or whatever — unless the physician has performed an adequate history and

physical evaluation to establish a diagnosis and to identify underlying conditions and/or any contraindications to the treatment being recommended or provided," Dr Winn said.

That language likely will be submitted for review by the federation's House of Delegates next April. If approved, it would become federation policy and would be promoted to state medical boards throughout the country.

Whatever action the Texas Legislature or any other governmental entity ultimately takes must treat "cyber activity" the same as physical activity, Dr Levy says. "If an activity is prohibited in the physical world but not on the Internet, then the Internet becomes a safe haven for criminal activity," he said.

Establishing credibility

While regulators of medical licensees are looking at their options, their ability to police the Internet is limited. Their actions can address only their own licensees. They have little or no authority over activities that do not involve licensed physicians or over the reliability of medical information posted on health-related Web sites.

Some critics say many Web sites are full of inaccuracies and bad medical advice and often fail to give the sources of their information or reveal financial sponsorships that might raise conflict-of-interest questions. Much of the information on these sites has undergone little or no scientific review.

"I hope and believe that these sites, if they are run by credible people and they are putting their reputations on the line, are spending a great deal of time in disseminating accurate information," Dr Levy said. "But I am concerned, with all these sites springing up, whether people truly are supplying information or whether they are supplying a subconscious or subliminal suggestion trying to sell a product." ★

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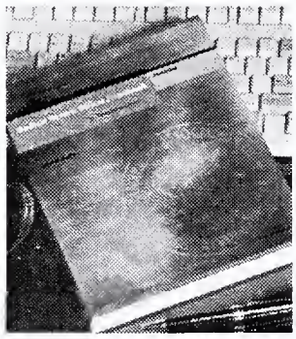

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Fight to the finish

The race to be the new medical school on the border heats up

Ray-Mel Cornelius

This past August, Texas Tech University announced its intent to transform its 2-year medical school in El Paso into a 4-year medical school. That announcement essentially shouted what the rest of the medical education community had been whispering: the race for a new medical school on the Texas-Mexico border had begun. ➤➤

By Monica Maldonado, Associate editor

While other players, like The University of Texas Health Science Center (UTHSC) at San Antonio, have begun inching clerkships into existing practices and expanding residency programs or regional academic health centers (RAHCs), Texas Tech's proposal jumps in headfirst. What's surprising about many of these proposals is the number of questions that exist regarding their implementation, operation, and funding. Physicians want answers, and they especially want to know if these proposals will lead to another town-gown war. But the medical schools want to avoid that conflict, and at least one is offering intriguing new ways to work with private physicians so that all sides, including the patients, win.

A history of underfunding

The path to the development of a new border medical school begins with a history of higher education underfunding for the region, and from there it splits, winds, and crosses via political scrambling, cries from the communities, and the dash for the medical-student dollar. Most people point to the 1987 MALDEF case as the origin, a suit initiated by the Mexican American Legal Defense and Education Fund that accused the state of depriving South Texas of higher education funds for its largely Hispanic population. In the end, Texas won the case, but the startling funding and demographic disparities the suit brought to light prompted changes by the Texas Legislature.

One was the South Texas/Border Region Health Education Initiative of 1997, in which legislators decided UTHSC-San Antonio should expand to South Texas communities from Laredo and Eagle Pass to the Rio Grande Valley and to Corpus Christi and the Coastal Bend.

From there, the paths split. Since then, a steady stream of action has headed toward the border, pointing toward the inevitability of a new medical school there. Meanwhile, the Texas Medical Association continues to promote a freeze on the number of medical student slots for Texas.

Town-gown redux?

The UT system didn't exactly ask for the impending RAHC in the Rio Grande Valley (the first year they would send students would be 2002). James Guckian, MD, the UT system vice chancellor for health affairs, says the Valley legislative delegation, not UT, pushed for the expansion and looked to UT for input. Despite the not-guilty plea, the UT system was immediately met with suspicion by practicing physicians in the area for whom the memory of the dispute between The University of Texas Medical Branch at Galveston (UTMB) and local Galveston physicians was still fresh.

In 1995, UTMB faced revenue shortages and a dwindling patient base for training new physicians. It decided to compete for private primary care and specialty care patients by opening primary care clinics in and around Galveston, which left private physicians there reeling. So it's no surprise that physicians in the Rio Grande Valley are wary of the UT system's intentions.

According to the legislation establishing the RAHC, the concept is to provide third- and fourth-year clinical and resident education in Cameron, Willacy, Hidalgo, and Starr counties. New facilities for administration and research will get funds from the state, but a new teaching hospital won't. Students from San Antonio would elect to spend their third and fourth years there, similar to the arrangement Texas Tech has with its RAHC in El Paso. Because it will draw students from existing 4-year medical schools, it will not create any new slots for medical students.

Beyond that, questions still exist about how the RAHC will actually play out, and the physicians from the Hidalgo-Starr and Cameron-Willacy county medical societies are hungry for answers. How much indigent care will the RAHC take on? How will private physicians be incorporated into the plan? Is there a sufficient patient base to support all these doctors? Unfortunately, the UT system says it still can't answer some of these questions.

But the two medical societies responded differently to the proposal. Hidalgo-Starr distributed fliers to inform the public about the RAHC, describing it as "subsidized competition by the state." It also wrote letters of opposition to the UT chancellor. Cameron-Willacy, however, took a different route. Realizing the RAHC's inevitability, the medical society decided to work with the UT system to make sure its physicians' voices would be heard.

"Our secret agenda is that students will come here and enjoy it, and by the time this thing is running, we'll have about 100 students wanting to rotate here and we'll have to be selective."

Trying to keep politics out of its decision-making, UT hired a consulting firm to advise the system on the best setup for the RAHC. In the end, between Cameron County's willingness to cooperate and a weak proposal by Hidalgo County to host the main teaching hospital for the RAHC, university regents designated three RAHC sites for medical education and research. They were Brownsville and Harlingen in Cameron County and McAllen in Hidalgo County — though McAllen has not committed to participate. Su Clinica Familiar and Valley Baptist Hospital, both in Harlingen, will partner with the RAHC and receive $25 million toward expansion and construction.

"People in Cameron County were willing to work with the project because we felt the advantages and benefits to the community would be tremendous," said Stanley Fisch, MD, a Harlingen pediatrician whose clinic hosts medical students on their pediatric rotations. "Our secret agenda is that students will come here and enjoy it, and by the time this thing is running, we'll have about 100 students wanting to rotate here and we'll have to be selective."

In a more recent development, still

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evolving from the 1997 initiative, UTHSC-San Antonio agreed to expand to Laredo, the result of a bill passed during the last session of the legislature. Lawmakers approved the expansion under the stipulation that someone else — in this case, Laredo — donate the land and pay for construction of the facilities. Laredo was only too happy to comply. Before the bill was even passed, it had set up a nine-acre plot of land adjacent to a new 325-

Do border counties need more physicians?

The following numbers from the Texas Medical Association's Medical Education Policy Department reflect 1999 information on those counties that might host a new medical school or a medical school expansion. The first column shows the number of patients per family practice physician (a subset of the primary care physician group than can also include internists and obstetrician-gynecologists) because counties with smaller populations usually have more general and family practice physicians than other types of primary care physicians. The second column shows the number of patients per all types of direct care physicians, including primary care (in general, the lower the number, the more physicians there are in that county).

	No. of Patients Per General/Family Practice Physician	No. of Patients Per Direct Care Physician
Texas Tech		
El Paso	8,300	1,064
The University of Texas Health Science Center at San Antonio Regional Academic Health Center		
Hidalgo (McAllen)	5,336	1,092
Starr	10,287	6,858
Cameron (Harlingen)	8,636	894
Willacy	3,319	1,810
The University of Texas Medical Branch at Galveston		
Galveston	4,246	643
Brazoria	4,441	1,586
Chambers	20,841	5,210
The University of Texas Health Science Center at San Antonio		
Laredo Campus		
Webb (Laredo)	7,399	1,233
Texas A&M University Coastal Bend Health Education Center		
Nueces (Corpus Christi)	3,115	518
Kleberg	3,565	1,528
San Patricio	3,399	1,743
Texas	**3,831**	**667**

bed hospital under construction and had raised $4 million in private donations toward construction of the administration building. The state itself allocated $16 million over 2 years for the project but dictated that no state funds would go to the eventual construction of a new teaching hospital.

Unlike the RAHC in the Valley, the Laredo site is an expansion of the entire health science center, not just the medical school, which will build upon existing programs in nursing, dental, medical, and allied health. The school wants to slowly increase the number of clinical clerkships there for its third-year students, but it will not increase the number of medical students. As of this writing, the school was working with Mercy Hospital to initiate a family practice residency program. But, as UTHSC-San Antonio reports, the purpose of the Laredo extension is to enhance the medical infrastructure of the region, not just increase the number of physicians there.

A new approach to town-gown

The Texas A&M System has a major project of its own brewing in Corpus Christi. Again, the local legislative delegation led the push for a bill directing the board of the Texas A&M Health Science Center to establish the Coastal Bend Health Education Center (CBHEC). The original proposal also suggested increasing the incoming class size; however, A&M dropped that idea to wait for the results of studies by TMA and the Texas Higher Education Coordinating Board on workforce needs in rural areas, says Jay Noren, MD, chancellor for health affairs for Texas A&M.

The CBHEC proposal is a little different from others in that it takes the health of the entire community into account, proposing expanded training in nursing, public health, and other allied health professions, and recruiting local high school students into the medical profession. (See "After Hopwood," February 1999 *Texas Medicine,* pp 56–59.)

Dr Noren says one detail of the medical education feature of the proposal would help avoid the town-gown issue. Local practicing physicians would be recruited and trained to teach third-year

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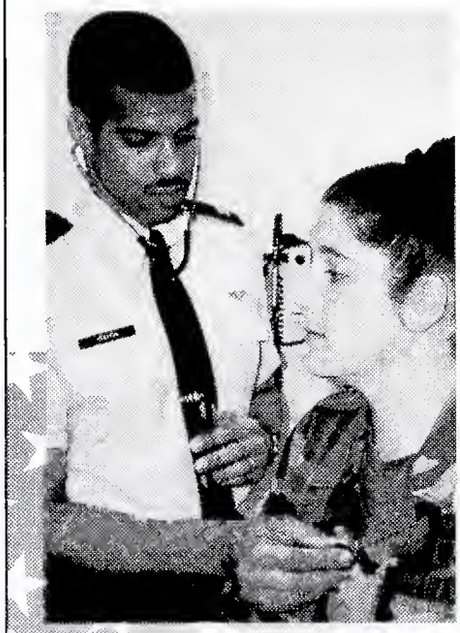

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students doing clerkships. Some of them would be compensated. "We already do a lot of community-based education because we don't have a university hospital," explained Dr Noren. "One of our principal objectives is to avoid the town-gown problem, and we think this will help." A&M would also work to increase the number of fourth-year elective rotations in the Coastal Bend area.

While TMA opposes any increase in the number of medical student slots for the state, the TMA Council on Medical Education told the legislature that the community training program sounded promising and that the proposal jibes with TMA policy of encouraging medical schools to expand community-based programs into underserved areas of the state. Acknowledging that the idea has potential kinks, however, the council hosted a forum on the CBHEC community-based training idea in November to explore and learn more about the teaching model and its potential impact on the community. The results of that forum were not known at press time.

Bill Griffin, MD, president of the Nueces County Medical Society, says physicians there, too, had doubts about the CBHEC proposal. "But now the physicians in our area are for it. Once people understood the concept, they were more apt to buy into it," he said.

"It makes sense for our part of the state because so many of our physicians train elsewhere. We also see this as a possible solution to some of the physician shortages we've been having," Dr Griffin said.

Cards on the table

Texas Tech's August statement is the only announcement of a plan for a new, 4-year medical school, and it is giving itself about 10 years to work it all out. Tech's El Paso School of Medicine now trains about 100 of the third- and fourth-year students on the Lubbock campus and about 170 residents in 10 programs. The proposed school would be smaller than the Lubbock school but would provide patient care, medical training, and medical research.

Once again, the push came from a legislator, Sen Eliot Shapleigh (D-El Paso), who wanted a 4-year medical school as part of the Border Health Initiative, which was allocated $50 million of the settlement of the state's lawsuit against the tobacco industry during this past legislative session. After years of fighting with Tech's Lubbock campus over funding, Senator Shapleigh finally persuaded Tech to agree to expand its current campus in El Paso.

"This *is* a 10-year plan," Joel Kupersmith, MD, dean of the Texas Tech medical school, emphasized, and therefore it's too early to discuss how it will all play out. But according to Senator Shapleigh, the new school will emphasize research and enlist private physicians to help train students. "We have worked hard to address the town-gown issues by shifting the mission of this health campus to research," he said.

The El Paso County Medical Society reports little reaction so far from local physicians. But past president John M. Tune, MD, in a letter to the *El Paso*

Countdown to a border medical school

1987	The Mexican American Legal Defense and Education Fund (MALDEF) files a lawsuit claiming historical underfunding of border universities.
1991	Brownsville district court rules in favor of MALDEF.
1993	The Texas Supreme Court overturns the Brownsville court ruling, citing no discrimination.
1993-1996	The legislature establishes the South Texas Initiative and appropriates $500 million to improve higher education, excluding a medical school.
May 1997	The legislature authorizes establishment of the South Texas Regional Academic Health Center (RAHC) in conjunction with The University of Texas System and authorizes spending $2.25 million in general revenue funds and $30 million in tuition interest bonds.
December 1997	The UT System hires the Kaludis Consulting Group of Washington, DC, to oversee the RAHC site application process.
May 31, 1998	The Texas Higher Education Coordinating Board is required to issue a status report on the RAHC to the House Committee on Higher Education, Senate Education Committee, and UT System.
August 1998	The University of Texas Board of Regents appoints The University of Texas Health Science Center (UTHSC) at San Antonio as the parent school for the proposed RAHC for South Texas.
May 1999	The legislature approves the proposed UTHSC-San Antonio expansion campus in Laredo and approves Senate Bill 590, which paves the way for the establishment of the Coastal Bend Health Education Center.
August 1999	Citing the unique health challenges of the El Paso border community, Texas Tech announces its intention to transform Texas Tech University Health Sciences Center at El Paso into a 4-year medical school; projected implementation is 10 years.

Times shortly after Tech's announcement, said he supports the idea. "[Texas Tech] now realizes that if they do not take action to create a university medical center in El Paso, the UT system will beat them to it in Laredo or Harlingen," he wrote. "The medical community and the people of El Paso will hold [Tech Chancellor John] Montford to this promise and will demand our legislature's prompt action and support on this issue."

evaluate the impact of San Antonio's expansion to Laredo. The others, due in August 2000 and January 2001, will look at the CBHEC and the Border Health Initiative and determine the need for medical training along the border in general.

Stacy Silverman, program director at the Coordinating Board, says the goal of the impact statements is to "paint a picture" of what will happen locally, regionally, and at the state level

"It makes sense for our part of the state because so many of our physicians train elsewhere. We also see this as a possible solution to some of the physician shortages we've been having."

Evaluating the need

Marcia Collins, TMA's director of medical education studies, says that if a new medical school is built, residency slots among the schools might have to shift to avoid creating new slots. UTMB, in fact, has already begun downsizing and shifting resident training programs. But with so many of the medical schools' plans still in their infancy, there's no way to guess how the state would absorb more students from a new medical school.

This year, however, at least two state agencies have been assigned to try. The lieutenant governor's office has charged the Senate Committee on Health Services with "assessing the preparedness of the Texas health care workforce to meet the health care needs of Texas beyond the year 2000." A representative from the committee says it is unwilling to predict how that will affect the expansion of medical schools to the border. The committee's final report is due no later than September 1, 2000.

Also, the legislature has assigned the Texas Higher Education Coordinating Board four interim studies on the impact of the proposals for medical school expansion, the first of which is due January 1, 2000. That study will

once the expansion is up and running. "We ask, 'Is it going to draw students away from other schools? Or is there going to be a groundswell of students who would otherwise not consider health studies?'" she said.

"We know that anecdotally South Texas high school students are less likely to go to a bigger city for school if it draws them away from their communities. If a school in that area did offer those opportunities in that area, then maybe those graduates would stay in that area and provide care for that area," Ms Silverman added. "That can't be a bad thing." ★

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For more information, call Larry BeSaw, editor, at (800) 880-1300, ext. 1383, or (512) 370-1383, or e-mail larry_b @texmed.org. Also consult the TMA Web site at www.texmed.org.

Y2K 2L8?

Practical last-minute preparations for the countdown to 2000

Dave Albers

Consensus has it that the bite of the Y2K bug won't be life-threatening for Texas patients, but administrative systems may need the defib paddles come January 1 if precautionary preparations haven't been completed in a few days.

As Larry White, chief information officer for MacGregor Medical Association, puts it, "If you can't get a bill out the door, you'll be going out of business." ➤➤

By Laurie Stoneham

The 18-clinic multispecialty group in Houston has been rigorously preparing for the year 2000 since April. Cross-functional teams have considered and attacked a variety of potential problems. The effort has included everything from the assessment and remediation of medical devices to the establishment of detailed contingency plans in the event of power failures or other emergencies. A Y2K rollover squadron will ring in the New Year on-site with a backup team on call in the event of major interruptions.

Mr White says he anticipates some failures, "but they will appear in back-end systems and not affect patient care. And even in the worst of circumstances, we'll be able to generate and mail HCFA 1500 forms."

In case you haven't been paying attention, here's why the computer wizards are worried: the Y2K problem involves the processing of year 2000 dates in information systems. Past computer industry practice has been to record the year portion of dates using only the final two digits. When the year 2000 begins — unless corrective action is taken — many computer systems will be unable to correctly indicate years beginning with "19" and "20" and to accurately determine 21st century dates. As a result, some computer systems may fail or produce erroneous information, causing widespread disruption, unless they are made Y2K compliant to process year 2000 date information.

21st century transmissions

An avalanche of paper processing is precisely what the Texas Health Information Network, the state's largest claims clearinghouse, has been working diligently to avoid, according to David Renfro, manager of provider automation sales/marketing for Blue Cross and Blue Shield of Texas.

Mr Renfro points out that the Health Care Financing Administration (HCFA), payers, and vendors have been inundating physicians with information to alert and educate them on Y2K issues. Blue Cross and Blue Shield began assessing the readiness of physicians' offices to submit electronic claims last fall with a series of three surveys. "We've received a tremendous amount of cooperation from the medical community," Mr Renfro said, "and overwhelmingly, providers indicate that they will be Y2K compliant."

The formats for electronic claims data submission are all date-ready. However, that doesn't guarantee a system is compliant in all areas, Mr Renfro emphasizes. "There's a great deal more involved with compliance than claims submission. Physicians need to be working with their system hardware and software vendors who can address their readiness requirements."

What to do at this late date

Physician office staff members surveyed by *Texas Medicine* say they have either purchased new computers or upgraded software to overcome the century's nastiest and most expensive glitch — or media hype, depending on your point of view.

But say you've taken a "let the chips fall where they may" attitude, choosing to focus on sick patients instead of possibly sick embedded chips. As the calendar pages flip ever closer to the year 2000, what should be done regarding the bug whose menace is still a mystery? Well, you probably don't need to fool with testing your coffeemaker or even your scanner at this point. However, it would definitely be prudent and practical to check out critical systems — those machines crucial to the life and safety of your patients and your business.

Contact the manufacturer of this equipment. The most efficient means at this point is to look at company Web sites (see "Additional Resources"). These sites typically will have test programs, along with instructions on what you can do to correct problems.

Additional resources

Below is a sampling of Web sites and phone numbers that have some of the answers you'll need to protect yourself from the millennium bug:

Computer software manufacturers

Adobe: www.adobe.com/newsfeatures/year2000/prodsupport/html
Apple: www.apple.com/about/year2000
Corel: www.corel.com/year2000/index.htm
IBM: www.software.ibm.com/year2000
Microsoft: www.microsoft.com/Y2K
www.microsoft.com/technet/year2k/pca/pca.htm
Symantec: www.symantec.com/y2k/y2k.html

Computer hardware manufacturers

Dell: www.dell.com/year2000
Gateway: www.gateway.com/about/Y2K/index.shtml
Hewlett-Packard: www.hp.com/year2000
IBM: www.ibm.com/ibm/year2000
Intel: www.intel.com/support/year2000

Organizations

American Medical Association: www.ama-assn.org
Health Care Financing Administration: www.hcfa.gov/Y2K; (800) 958-HCFA
President's Council on Y2K: www.Y2K.gov; (888) USA-4-Y2K

Miscellaneous

Checklist of products to test: y2k.y2kbase.com

The American Medical Association also has a thorough testing instrument, PCReady2000, available on its Web site at www.ama-assn.org that you can use to test operating components in your computer.

Claims claims

With regard to claims processing systems, you want to learn from the manufacturer or vendor who sold you the equipment:

- Is the system Y2K ready?
- What needs to happen for you to be able to produce and submit electronic claims in January 2000 and beyond?
- If necessary, will assistance be provided for Y2K date verification tests?
- Is written documentation of Y2K readiness available?
- What are the contingency plans in the event of problems?

Caring for your Medicare business

A national hue and cry has proclaimed that the health care industry is woefully behind in its Y2K efforts. Most of this is based on HCFA statistics. The organization points to a recent experience with Nationwide, a Medicare contractor. The company performed a dummy claims run with 346 providers. Of the 136 failures that occurred, 9 were serious. HCFA admits that corrections are often simple, but they have to be revealed before remedial action can be taken. HCFA advises:

- Send your carrier a test claim dated January 2000 to ensure hardware and software compliance, or make sure your billing service has done so.
- Perform this test as soon as possible to identify problems and have the time to fix them.
- Don't rely on paper claims as a backup plan. Paper claims will cause a huge backlog and extend payment times.

Fatality reports

Could the bite of this bug cost lives? Not likely, according to critical care physicians around the state.

The popular press has incorrectly and unjustifiably created fear among the public, says Richard Hecker, DO, chief of anesthesiology at CHRISTUS Santa Rosa Hospital in San Antonio. "The fact is, most of the equipment we use is not date-sensitive. We've looked at those that are, and they are ready. So bottom line, we don't think that Y2K will be that big of a deal."

Sam Roberts, MD, chief of emergency medicine at Seton Medical Center in Austin, says the biggest headache is that manufacturers aren't guaranteeing compliance, so it's been a time-consuming "bit-by-bit" assessment. He is confident that the major life-sustaining systems will operate properly.

The medical director of emergency medicine at Northwest Texas HealthCare System in Amarillo also is optimistic. "If MIS fails us," said Kevin Allen, MD, "the worst scenario is that we can no longer process and register patients, but we will still be able to care for all levels of emergencies." In terms of critical patient care, he notes that backup generators are in place in the event of an electrical grid failure. Dr Allen added, "A task force will be on-site from 10 pm to 2 am, prepared to assist in the event of major interruptions."

Happy New Year

Despite years of painstaking effort and billions of man hours and dollars, the hysterically ironic aspect of this whole business is that it really is all about zeros, because that's how many people know what truly will happen at 12:01 am, Saturday, January 1, 2000. ★

Laurie Stoneham is an Austin freelance writer.

Smart test

You can take advantage of a Texas Health Information Network test program by transmitting Y2K compliant claims files as a "test" to the normal rEDI-link Blue phone number currently used, with the appropriate submitter number and password. Date(s) of service, date of birth, hospital admission date, and date of accident or injury should consist of year 2000 dates. To confirm that dates submitted are for the year 2000, a normal response report will be received and the test files should reject for "invalid/future dates." If any changes are made to hardware and/or software after the test, another test should be considered.

Protecting your home and family

Okay, so it's too late to build a straw bail home in the Texas Hill Country. Still, many experts are suggesting that some basic preliminary precautions are in order for possible electrical and water supply interruptions. Such preparations would be similar to emergency preparedness and include having on hand:

- Hard copies of important documents stored on your home computer, including banking, financial, brokerage, and/or tax statements.
- A supply of flashlights and a battery-operated radio or television, along with replacement batteries.
- A 3-to-7-day supply of nonperishable (canned, dehydrated) food and bottled water.
- Firewood and other items (blankets, coats, hats, gloves) for keeping warm.
- A 30-day supply of prescription and nonprescription medications and first aid equipment.
- Extra cash (7 to 30 days' worth).
- A full tank of gasoline in all automobiles.
- Alternative heating and cooking devices, which should be used with caution. Generators should be stored outside the home in a well-ventilated area and should be connected to specific appliances, not to the home's electrical system.

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TexasMedical Association

"I felt like a doctor again."

A Texas surgeon rediscovers the joy of medicine in Honduras

Photo courtesy of Bruce McDonald, MD

This woman with a huge goiter was among the many Hondurans helped by the Texas surgical team.

Editor's Note: In the November issue of *Texas Medicine,* Austin surgeon Bruce McDonald, MD, began his account of the medical mission that he, his wife, and daughter took to San Pedro Sula, Honduras, in August with a team of volunteer physicians and other health care professionals from Austin and Round Rock. Their initial excitement was tempered by the reality of the primitive conditions in the Hospital Leonardo Martinez, but they quickly set to work treating patients. Here is the conclusion of his story.

Monday, August 9
Surgery begins

As planned, we arrived at the hospital at 8 am sharp. We were ready to go, but the hospital was not. The instruments and packs we had prepared remained unsterilized. There was a problem with steam generation, so we were forced to wait. Meanwhile, a local family doctor managed to get sterile packs and was working on four tubal ligations in one of the rooms we prepared for our surgeries. Tempers flared, everyone was on edge. After Dr Samora (the Americans' Honduran liaison) arrived, the situation improved marginally. ➤➤

By Bruce McDonald, MD

The first surgery, a suprapubic prostatectomy, began at 11 am. I managed to get a hernia going in another room, but it was a comedy of errors. Just as the patient got his spinal and was prepped and draped, the power went out. We were informed that a fire in the electrical generation plant had caused a power outage that affected the entire country. We were able to perform the surgery with the help of a flashlight, natural light from the windows, and a "spotlight" caused by a gaping hole in the roof. We didn't miss the cautery — it had never worked reliably and was only a source of frustration.

Things weren't improving. Inside the operating room, the afternoon heat and humidity were becoming oppressive. The toilet didn't flush, and the odor was overwhelming. We couldn't get a breath of fresh air because Nurse Ratchett (the surgical team's nickname for the domineering Honduran OR supervisor) had run out of *botas* (shoe covers). By 1:30 pm, we had power again and started on our next patients.

Dr Samora had disappeared off the face of the earth. Dr Ed Lewis, our anesthesiologist, managed to wire one of the formerly useless cautery machines, and Dr Elizabeth Rutledge was able to do a TURP (transurethral resection of the prostate).

The conditions of the hospital were deplorable; the conditions of many of the patients were equally shocking. These people were not only poor, but they also had medical and surgical conditions that had worsened from neglect. They were simply beyond the capabilities of the local surgeons.

The day's last patient had a large inguinal hernia and a complete AV block following several heart attacks. We decided to operate under local anesthesia with sedation. His heart rate during the surgery was 35, and he breezed through without a hitch.

During the first day of operating, we did six inguinal hernias *gigantes*, two suprapubic prostatectomies, a TURP, and a cholecystectomy. We were exhausted, but we knew we had accomplished a great deal under duress. We finished at 8 pm and headed for the showers and the hotel bar. Despite the fact that hot water was available only in the mornings, it felt good to be clean.

Tuesday, August 10
The pace accelerates

We arrived at the hospital at 8 am. The word was out and the floodgates were open. I saw 25 patients that morning. Most had been properly triaged, and we were able to do their surgeries. Some didn't need surgery, and some were beyond what I considered safe under the conditions.

One woman came with her infant son who had an enlarged lymph node in his neck. She had been told that he had cancer. He did not. A little reassurance was all that was necessary.

A young man with a huge hiatal hernia complained that he lost his stomach contents every time he bent over. He was quite thin, and I knew that under the proper circumstances, we could really help him. I also knew that the conditions at Hospital Leonardo Martinez — inadequate lighting, no cautery, and the ever-present chance of power outage — were too risky for his case. I apologized and explained that we did not have the equipment to do the repair.

It was very difficult to turn away patients, but we had to remember that we were first and foremost ambassadors from our country — all the good that we might accomplish could be wiped out by a single bad case. *Primum non nocere* was the guiding principle.

Midmorning. More hernias *gigantes*. One woman came in with a huge incisional hernia. Somehow she had managed to get her own mesh and a suction catheter. She came NPO. We gave her high marks for ingenuity and scheduled her for the afternoon.

Dr Michelle Irwin found a gynecologic case. I went to the hospital ward to check the patients.

The med-surg unit was a large room with 32 beds, and minimal, if any, air conditioning. The men were mixed in with the women, with no curtains between beds. Families were responsible for providing food and pain medication. All things considered, my patients were doing well. On to the OR.

On the way to the operating room, I was stopped by a woman with a huge goiter. She had not been able to swallow solid foods for more than 2 years because of the size of her thyroid. We put her on the schedule for Wednesday.

The surgeries started late but I was able to do five inguinal hernias, one incisional hernia, and a gallbladder. Because we would not be around to remove the sutures, I closed all incisions with 4-0 Vicryl subcuticular sutures. They turned out to be a real crowd-pleaser in the post-op ward. Apparently, the standard of care in San Pedro was 2-0 silk mass sutures.

Late afternoon. More challenges. We had a problem with the tetracaine spinals. The medical supply company had given us the liquid, which is very unstable. Many of the spinal anesthetics were less than effective and we had to finish with local anesthesia. The gallbladder surgery was completed with Marcaine local and ketamine. By 6 pm, only a TURP was left, and most of the team returned to the Gran Sula Hotel. We showered and met at the hotel bar.

Back at the hospital, Dr Rutledge and Dr Jack Jacobson encountered a large bladder stone and had to open. When they returned to the hotel sometime after 9:30 pm, they told us the story of the three-legged cat. Apparently, during the suprapubic prostatectomy, the kick bucket was knocked over and everyone looked up to see a three-legged cat running from the OR with a

The conditions of the hospital were deplorable; the conditions of many of the patients were equally shocking. These people were not only poor, but they also had medical and surgical conditions that had worsened from neglect.

Photo courtesy of Bruce McDonald, MD

The post-op ward in the Hospital Leonardo Martinez was crowded while the visiting surgical team was in town.

The total general surgery count for the day was 10 hernia repairs, a partial glossectomy for tumor, a thyroidectomy, an open cholecystectomy, an epigastric hernia, a resection of a malignant melanoma, and an umbilical hernia.

prostate in its mouth. We ordered pizza and had a feast in the hotel bar.

Later that evening, we ran into two Americans, Jaime and Lisa, who had been running missions in Honduras for several years. We told them our experiences, and they volunteered to come to the hospital in the morning to help us with our problems. The timing was perfect. We had run out of scrub sponges and were starting to reuse them. We were just about out of Ringers lactate (IV solution), and the tetracaine for the spinals was not doing the job. Jaime and Lisa told us they would help find supplies. We were encouraged by their kind offers, and the day ended on a high note.

Wednesday, August 11
A banner day

Three American soldiers were shot to death by gangs about two blocks from our hotel. Lynn Carter, Dr Jacobson's nurse, had heard a commotion outside her hotel window and saw a bloody, dead body lying in a pickup truck surrounded by local police with automatic weapons. The word was passed on to the students, who finally stopped asking if they could go out at night by themselves.

We arrived at the hospital at 8 am to make rounds. The local physician had discharged all of my patients from yesterday, including the gallbladder removal from last night and the massive incisional hernia. Patients started coming out of the woodwork. They stopped us at the OR door with abdominal sonograms showing gallstones, or large goiters and hernias.

Lisa proved to be a good interpreter and knew how to get things done in Honduras. The pace picked up and we managed, through Lisa, to get needed drugs. Unfortunately, the entire hospital was out of water. We had to carry water from across the street for cleaning and scrubbing.

We divided into teams, and the surgery moved much more quickly. The urologic team consisted of Drs Rutledge and Jacobson with Lynn Carter and Dan Eckert (administrator of the Round Rock Ambulatory Surgery Center). The general surgery team consisted of myself with nurse Marilyn Kasper and Janice Walter (an operating room technician). We kept the students rotated through as assistants, and they also helped turn the rooms around.

The patients began pouring in. Dr David Gillory, our orthopedic surgeon, had gone to the other public hospital, which had 400 beds. He did several surgeries: a forearm, a femoral rodding, and removal of a bullet from a knee. They were supposed to do more surgery in the afternoon, but the hospital ran out of drapes. He said there were more than 130 orthopedic cases at the public hospital, but a strike by hospital employees and the lack of physicians and supplies left them hamstrung.

The OR staff was actually starting to be helpful. The massive goiter was the case of the day. We got all of the cauteries into the room, hoping at least one would work. No luck. We started without them. The dissection proceeded without incident. A large tumor of the left thyroid lobe. The upper pole divided and the hemostat popped off. Brisk bleeding ensued; direct pressure was applied until the thyroid could be removed. It was a huge adenoma. We found the superior thyroid artery and ligated it. Operative time was less than 20 minutes. The surgery was observed by many of the local staff, so word of the case circulated quickly. For a brief moment, I was *Cirujano Supremo*. It felt good to be appreciated, but I knew I was only as good as my last case and I had many more ahead of me.

My last case of the day was a gallbladder in a moderately obese woman. No cautery. No laparotomy sponges — we had to sterilize and use bath towels for sponges. Lynda Peters, the administrator for Medico, arrived and uncovered more laparotomy sponges. We pushed on.

The total general surgery count for the day was 10 hernia repairs, a partial glossectomy for tumor, a thyroidectomy, an open cholecystectomy, an epigastric hernia, a resection of a malignant melanoma, and an umbilical hernia. The urology group turned out a bunch of suprapubic prostatectomies, removed a kidney stone, and repaired a hypospadias. A truly banner day.

At 11 pm, we sent out for pizza. We had a feast in the OR. Everyone was completely pumped up. We could have continued to operate all night.

Thursday, August 12
Our last day

It felt like Christmas. We convinced Dr Samora to let us into Nurse Ratchett's private stash. We loaded up on shoe covers and hats, drapes, #15 blades, and gloves.

Surgery moved along well with two rooms for general surgery. The word was

Our team of 22 volunteers worked together to accomplish the goal of providing care for those less fortunate than ourselves. Sure, there were hassles and abysmal conditions, but these were because of the oppression of poverty and ignorance, not oppressive Medicare and managed care rules.

Photo courtesy of Bruce McDonald, MD

The hospital operating room was primitive, but the Texans were still able to perform surgery.

out about the quality of our care, and Norma Reyes, the head nurse, brought in a friend for gallbladder surgery. We added her to the schedule as a PR move.

Private surgeons arrived to watch our techniques and learn from us. Today's highlight was the largest thyroid I had ever seen. I elected to do a subtotal because it had been there for 20 years and was most likely benign. I also knew the patient did not have the money to buy thyroid replacement medicine. The visible thyroid was only the tip of the iceberg. It nearly encircled the neck. After much pulling and blunt dissection, I managed to free it anteriorly and from the trachea. It was divided in the midline and eventually succumbed to surgical siege. The patient recovered without a hitch.

Thursday afternoon. Wall-to-wall hernia surgery — six in all — and finally Norma's friend with gallstones. A local surgeon scrubbed in on the hernia repairs. He was fascinated with the plug-and-patch method. I showed him how to do it and gave him some of our leftover plugs.

A tropical rainstorm developed and between the air conditioner, a noisy suction machine, and the rain pounding against the metal roof, it was impossible to communicate with each other. Dr Jacobson had two more TURPs scheduled. The first went very badly. It was converted to an open procedure, as the prostate was too big to remove through the scope. Bleeding became a problem, and the case went very late.

One of the visiting surgeons promised to get us two units of blood from the private hospital. It was outdated by a day. Back in OR 3, Dr Irwin, who is a universal donor, prepared to give a direct blood transfusion to the patient. The bleeding was slowing and clots started forming. Unfortunately, the first thing to clot off was the suction. The patient was closed and returned to the recovery room.

At 9:30 pm, we feasted on TGI Friday's carry out in the OR. We were exhausted and ecstatic. The first bus load returned to the hotel at 11 pm. The recovery, anesthesia, and urology people returned at midnight. We celebrated our successful mission until 2:30 am.

Friday the 13th
Morning comes early

Those of us who needed to make rounds and pack instruments left early for the hospital. The Honduran people are extremely hardy and have endured much hardship in their lives. They tolerated surgery extremely well. My gallbladder patient already had been seen by the local physician and discharged. Many of the patients had a day's walk to get back to their homes, some more.

We packed up the instruments and said our good-byes. All of the staff gave us hugs, and there were many tears. Even Nurse Ratchett brushed back a tear. We picked up the rest of the team at the hotel and headed for the airport at 10:30 am.

All things considered, we did a lot of good for many of the Hondurans. In 4 days of operating, the general surgical team did 28 hernia repairs, 2 thyroidectomies, 5 open cholecystectomies, a massive incisional hernia, a melanoma resection, an epigastric hernia repair, an umbilical hernia repair, and a mastectomy.

Drs Rutledge and Jacobson did more suprapubic prostatectomies in 4 days than most urologists do in a lifetime. There were also a hypospadias repair, kidney stone removal, and bladder stone removals. Dr Gillory managed to do some orthopedic surgery and Dr Irwin got to deliver some babies.

Although we went to Honduras to help the people, each team member was enriched by the experience in a personal way. One of our students, Brian Baird, who had no interest in medicine before the trip, has decided to pursue a career in anesthesia. My daughter, Shelby, who is interested in veterinary medicine, was fascinated by the anatomy and the actual performance of surgery. She cannot wait to do this again. She said this was the best trip she has ever taken. My wife, who has maintained her nursing license but has not been active in nursing for 20 years, has fallen in love again with the recovery room and is going back into nursing.

As for my own reflections on the trip, I was reacquainted with the joy of practicing medicine purely and simply. Our team of 22 volunteers worked together to accomplish the goal of providing care for those less fortunate than ourselves. Sure, there were hassles and abysmal conditions, but these were because of the oppression of poverty and ignorance, not oppressive Medicare and managed care rules. For a week I felt like a doctor again. ★

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78 Factors associated with fetal mortality in the triethnic population in Texas, 1993 through 1995
KIMDARY CHEK, MPH; GEORGE R. KERR, MD

Factors associated with fetal mortality in the triethnic population in Texas, 1993 through 1995

KIMDARY CHEK, MPH
GEORGE R. KERR, MD

We examined the underlying causes of fetal deaths reported for 1993 through 1995 in relation to the mother's ethnicity, reproductive history, and medical factors listed on birth and fetal death certificates.

The overall fetal mortality rate (FMR) was 6.3 per 1000 live births plus fetal deaths, and 5.6, 5.9, and 9.8 per 1000, respectively in pregnancies of white, Hispanic, and black women. Preterm birth (low birth weight) was a major predictor (or consequence) of fetal death, and extremes of maternal age, increased parity, and plural pregnancies were also associated with increased FMRs, especially in black women. The underlying causes reported on fetal death certificates were complications of the placenta, cord, and membranes (36%); ill-defined conditions arising in the perinatal period (23%); fetus affected by maternal complications of pregnancy (10%); fetus affected by maternal conditions unrelated to pregnancy (6%); and short gestation and unspecified low birth weight (5%); 14% of fetal deaths were associated with congenital abnormalities.

Factors reported most frequently were premature rupture of the membranes, disorders of amniotic fluid volume, pregnancy-associated hypertension, diabetes, anemia, previous preterm or small-for-gestational-age births, incompetent cervix, chronic hypertension, and sexually transmitted diseases. More than 40% of fetal deaths were not associated with any medical risk factor. FMRs associated with maternal anemia, cardiac disease, pregnancy-associated hypertension, eclampsia, and previous birth weighing more than 4 kg were at least 1.5 times higher in pregnancies of black women than in the other 2 ethnic groups. The underlying causes of fetal death provide few targets for their primary prevention; preventive efforts might better be directed to the closer surveillance and care of pregnant women with demographic, reproductive, and medical factors associated with increased risk.

INTRODUCTION

The infant mortality rate (IMR) is probably the single best indicator of the well-being of a population (1). But as neonatal mortality rates have fallen, fetal deaths have become the main determinant of perinatal mortality (2,3). One objective of Healthy People 2000 (4) is to reduce the fetal mortality rate (FMR) in the United States from 7.6 per 1000 live births plus fetal deaths in 1987 to no more than 5 per 1000 by year 2000. To identify potentially preventable causes of fetal death, we examined the underlying causes reported on fetal death certificates in Texas from 1993 through 1995 in relation to various demographic, reproductive, and medical risk factors.

MATERIALS AND METHODS

The Bureau of Vital Statistics, Texas Department of Health, maintains records of all reported fetal deaths, regardless of the length of gestation, and requires completion of a fetal death certificate if gestation is 20 weeks or more. Data from anonymous birth and fetal death certificates for Texas residents were obtained from the Bureau of Vital Statistics for the years 1993 through 1995. Ethnicity (white, black, and Hispanic) was determined by the mother's declaration; "other" ethnic groups were included in the total. Maternal ages were grouped into 5-year increments between 10 and 40+ years. Estimated gestational ages were grouped into 20 through 21, 22 through 25, 26 through 29, 30 through 33, 34 through 37, 38 through 41, and 42+ weeks. Birth weights were grouped into 500-gram increments. Maternal parities were grouped into 0, 1, 2, 3, and 4 or more. Plurality of birth was grouped as singleton, twin, and triplet or higher. Maternal education was grouped into below or above 12 years.

The underlying causes (*International Classification of Diseases* — Ninth Revision [ICD] [5]) reported on the fetal death certificates were ranked by percent of total fetal deaths. All variables were examined by ethnicity, and any value for 1 ethnic group that was at least 1.5 times those of both other ethnic groups was considered elevated. The occurrence of medical factors listed on birth and fetal death certificates was calculated per 1000 live births and per 1000 fetal deaths. The risk of fetal death associated with each medical factor was calculated as fetal deaths per 1000 live births plus fetal deaths associated with that factor. The statistical package SPSS-7.5 for Windows was used both to abstract and analyze the data.

RESULTS

From 1993 through 1995, a total of 964,412 live births and 6,084 fetal deaths were recorded. By ethnicity, 43.9% of live births and 39.3% of fetal deaths represented pregnancies of white women, 41.4% of live births and 38.8% of fetal deaths represented Hispanic pregnancies, and 12.7% of live births and 19.9% of fetal deaths represented black pregnancies. The total FMR was 6.3 per 1000 live births plus fetal deaths. The FMR of blacks was at least 1.5 times those of both of the other ethnic groups (Table 1).

FMRs decreased with increasing gestational age and birth weight, falling from more than 500 per 1000 live births plus fetal deaths for birth weights under 500 grams to 3 or fewer per 1000 with birth weights more than 2500 grams. The rates were highest in whites and lowest in blacks in each birth weight category under 2500 grams; thereafter, the rates were highest in blacks (Table 2).

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Table 1. Fetal mortality rates* by ethnicity, Texas, 1993 through 1995.

White	5.61
Hispanic	5.88
Black	**9.76**
Total	6.27

* Fetal deaths per 1000 live births plus fetal deaths.

Boldfaced value for 1 ethnic group is at least 1.5 times greater than those of both other ethnic groups.

Table 2. Fetal mortality rates by ethnicity and birth weight categories, Texas, 1993 through 1995.

	Fetal Mortality Rate*			
Birth Weight, g	White	Hispanic	Black	All
< 500	616	552	474	556
500-999	251	227	169	221
1001-1499	84	82	66	79
1500-1999	38	35	22	37
2000-2499	12	11	10	11
2500-2999	2.7	2.6	2.7	2.6
3000-3499	1.0	1.0	1.2	1.1
> 3500	0.7	1.0	1.3	0.9

* Fetal deaths per 1000 live births plus fetal deaths.

Maternal ages of 20 through 29 years were associated with the lowest FMRs (5.6 per 1000); the highest were associated with maternal ages less than 15 years and greater than 40 years (Table 3). In the group younger than 15 years, whites had the highest FMR; after age 20 years, blacks had FMRs at least 1.5 times greater than those of both other ethnic groups. FMRs increased with increasing parity and were highest in black pregnancies of all parities. FMRs also increased with increasing plurality of births. Maternal education less and greater than 12 years were both associated with a greater risk for fetal death in pregnancies of black women.

The top 5 underlying causes of fetal death, collectively responsible for almost 80% of fetal deaths, are shown in Table 4:

- *ICD 762: Fetus affected by complications of placenta, cord, and membranes.* The main contributors were the following: ICD 762.5, other compression of the umbilical cord (40% of the total); ICD 762.1, abruptio placenta and other placental separation and hemorrhage (25%); ICD 762.2, other and unspecified abnormalities of the placenta (13%); and ICD 762.7, chorioamnionitis (11%). The FMR associated with chorioamnionitis was elevated significantly in black pregnancies.
- *ICD 779: Other and ill-defined conditions originating in the perinatal period.* Most were attributed to ICD 779.9, unspecified conditions originating in the perinatal period.
- *ICD 761: Fetus or newborn affected by maternal complications of pregnancy.* The main contributors were ICD 761.1, premature rupture of the membranes (PROM, 49% of the total); ICD 761.0, incompetent cervix (20%); and ICD 761.5, multiple pregnancy (13%).
- *ICD 760: Fetus affected by maternal conditions which may be unrelated to pregnancy.* This code covers a wide range of problems such as hypertension, maternal infections, injury, malnutrition, chronic illnesses, and noxious influences reaching the fetus via the placenta.
- *ICD 765: Disorders relating to short gestation and unspecified low birth weight* (elevated significantly in the black population).

More than 14% of fetal deaths were associated with some type of congenital abnormality.

Among the medical risk factors, data were incomplete on the rates of preterm labor associated with live births and fetal deaths. The medical factors reported most frequently on birth certificates were pregnancy-associated hypertension, diabetes, anemia, sexually transmitted diseases (STDs), and PROM (Table 5). Those reported most frequently on fetal death certificates were PROM, disorders of amniotic fluid volume and pregnancy-associated hypertension, diabetes, anemia, incompetent cervix and previous preterm or small-for-gestational age (SGA) births, chronic hypertension, and STDs (Table 5). All of the medical factors except previous birth weight of more than 4000 grams were more strongly associated with fetal death than with live births; factors associated with an increase of at least 1.5 times on fetal death certificates included renal disease (x2), hemoglobinopathies, chronic hypertension, and previous preterm/SGA birth (each x4), PROM (x5), disorders of amniotic fluid volume (x6), and incompetent cervix (x17) (Table 5). FMRs associated with specific medical factors (per 1000 live births

Table 3. Association of maternal demographic and reproductive factors with fetal mortality rates, Texas, 1993 through 1995.

	Fetal Mortality Rate*			
	White	Hispanic	Black	All
Maternal age, y				
< 15	21.5	11.5	19.0	13.5
15-19	6.9	5.7	8.7	6.4
20-24	5.3	5.0	**8.3**	5.6
25-29	4.9	5.4	**9.7**	5.6
30-34	5.3	5.9	**11.7**	6.2
35-39	7.4	8.8	**13.7**	8.6
≥ 40	9.8	15.9	**24.1**	13.5
Maternal parity				
0	4.9	4.9	**8.8**	5.4
1	4.3	5.3	7.2	5.0
2	6.4	6.5	9.6	6.9
3	9.3	6.8	12.4	8.5
≥ 4	11.8	11.4	17.5	11.9
Plurality of births				
Singleton	5.3	5.5	**9.3**	5.9
Twins	16.7	21.9	25.9	20.2
Triplets or more	46.8	44.0	na†	42.6
Maternal education				
< 12 years	5.8	4.9	7.4	5.3
≥ 12 years	5.2	5.5	**9.1**	5.5

* Fetal deaths per 1000 live births plus fetal deaths.
† No triplet or more plural births.

Boldfaced values for 1 ethnic group are at least 1.5 times those of both other ethnic groups.

Table 4. Underlying causes of fetal death, Texas, 1993 through 1995.

	% of Fetal Deaths			
ICD*	White	Hispanic	Black	All
762: Complications of placenta, cord, membranes	41.1	32.0	32.0	35.5
779: Other/Ill-defined perinatal conditions	19.1	25.5	24.7	22.9
761: Fetus affected by maternal complications of pregnancy	9.5	9.5	12.8	10.0
760: Fetus affected by maternal conditions unrelated to pregnancy	5.2	5.1	7.4	5.7
765: Short gestation and unspecified low birth weight	3.9	4.5	7.4	4.9

* International Classification of Disease code

Boldfaced values for 1 ethnic group are at least 1.5 times those of both other ethnic groups.

plus stillbirths with that factor) were most elevated for incompetent cervix, disorders of amniotic fluid volume, PROM, chronic hypertension and hemoglobinopathy, previous preterm/SGA birth, renal disease, and acute/chronic lung disease (Table 5). About 10% of pregnancies that resulted in live births and 21% of those that resulted in fetal deaths reported "other medical factors"; 43% of fetal deaths were not associated with any specific medical risk factor.

The occurrence of medical factors among live births showed considerable ethnic variability, with the rates of cardiac disease, previous birth weight more than 4000 grams, and blood group isoimmunization being at least 1.5 times greater in pregnancies of white women compared with those of the other 2 ethnic groups (Table 6). Ethnic differences were fairly consistent from year to year, suggesting a systematic difference in either the incidence or reporting of those conditions. Ethnic differences were apparent also in FMRs associated with the various medical factors (Table 6).

DISCUSSION

This study was one of a series attempting to identify the preventable causes of death during early life in Texas. Studies of infant mortality (6) suggested that primary preventive strategies (preventing the underlying cause) should focus on sudden infant death syndrome, preterm birth and its respiratory complications, injuries, neural tube defects, obstetric and neonatal causes, and preventable infections; secondary preventive strategies (treating the underlying cause) should focus on treating the complications of preterm birth, bacterial infections, and specific obstetric, medical, and surgical problems. Studies of childhood deaths concluded that more than 90% of deaths open to primary prevention involved accidents, suicide, and homicide, with secondary preven-

tion applicable to a smaller number of medical, surgical, and infectious conditions (7). The present study focused on the preventable causes of fetal death.

Fetal deaths have always been an unanticipated tragedy of pregnancy (8). The first compilation of vital statistics for the United States was the 1850 Census (9); with very incomplete data, this document reported 377 stillbirths and 523,000 live births. By 1900, improved but still incomplete reporting suggested that about 10% of pregnancies might have ended in fetal death (10). By the 1920s, the rate was about 4% (in blacks, 7%) (11). A standard fetal death certificate was recommended for use after 1929, and the National Center for Health Statistics began to code causes and lifestyle risk factors for fetal death in 1989 (12). During the past decades, the FMR has fallen to current levels of about 0.7%–1% (13), reflecting a yearly US toll of more than 30,000 fetal deaths occurring after 20 weeks of gestation.

Determining the underlying causes of fetal death is often speculative without autopsy studies, and even autopsy definition can be difficult because of the sometimes extensive postmortem but prepartum tissue changes (14,15). Nevertheless, the main causes of fetal death are reported repeatedly to include extreme preterm birth, chromosomal and lethal malformation syndromes, abruptio placenta, placenta previa, umbilical cord compression, incompetent cervix, post-term pregnancy, amniotic fluid infections and volume disorders, pregnancy-associated hypertension and eclampsia, blood group isoimmunization, plural births, maternal diabetes, intrauterine hypoxia, and birth asphyxia (2,3,12–29). Demographic and reproductive factors associated with increased risk for fetal deaths have included extremes of maternal age, high parity, prior stillbirths and preterm births, substance abuse, inadequate prenatal care, unwed marital status, undereducated mother, and black race. No cause has been identified in up to 30% of fetal deaths (2,3,29).

Table 5. Medical factors associated with increased fetal mortality rates, Texas pregnancies, 1993 through 1995.

	Occurrence		
	Per 1000 Live Births	Per 1000 Fetal Deaths*	Fetal Mortality Rate†
Anemia	26.94	34.85 (1.29)	8.08
Cardiac disease	2.95	3.78 (1.28)	8.00
Acute/chronic lung disease	4.36	8.22 (1.88)	11.73
Diabetes	27.22	37.64 (1.38)	8.64
Hydramnios/oligohydramnios	8.57	51.28 (5.98)	36.33
Hemoglobinopathy	0.42	1.81 (4.36)	26.70
Hypertension, chronic	6.14	26.13 (4.26)	26.11
Hypertension, pregnancy associated	37.74	50.95 (1.35)	8.43
Eclampsia	3.23	5.10 (1.58)	9.84
Incompetent cervix	1.72	28.60 (16.64)	94.88
Previous birthweight > 4 kg	8.87	7.56 (0.85)	5.34
Previous preterm/SGA birth	7.17	28.93 (4.04)	24.81
Renal disease	2.45	5.10 (2.08)	12.92
Blood group isoimmunization	4.96	6.08 (1.23)	7.67
Premature rupture of membranes	17.29	89.58 (5.18)	31.60
Sexually transmitted diseases	21.10	23.01 (1.09)	6.82
Other	114.66	206.44 (1.90)	11.67
None	736.54	432.61 (0.59)	3.69
Unknown	20.42	127.55 (6.25)	37.86

SGA = small for gestational age

* Number in parentheses indicates the magnitude (x) of increased association of the medical factor with fetal deaths compared with live births.

† Fetal deaths associated with the medical factor per 1000 live births plus fetal deaths associated with the factor.

The present study of fetal death in Texas confirmed many of the sociodemographic predictors reported in other studies: FMRs were highest at the extremes of maternal age, with increasing maternal parity and plural births, and during the early stages of gestation. A previous study of infant mortality in Texas (30) concluded that while the incidence of very preterm, very low birth weight black births far exceeded that of white births, the risk of dying was actually greater for comparably small white infants. This curious (and unexplained) finding also appears to be present with fetal mortality.

The occurrence rates of the various medical factors in this study were generally comparable to national estimates (24,31,32); rates of anemia, diabetes, and disorders of amniotic fluid volume in Texas pregnancies that resulted in live births were somewhat higher.

At least in part, diagnostic and reporting problems make it difficult to compare studies about causes of fetal death (12). Nevertheless, the rates of medical risk factors from Texas pregnancies that resulted in fetal deaths are generally similar to the national estimates (24). The main risk factors for fetal deaths in Texas were PROM, pregnancy-associated hypertension, diabetes, anemia, previous preterm/SGA birth, cervical incompetence, chronic hypertension, and STDs. But the hoped-for value of the underlying causes of death to identify measures for primary preven-

Table 6. Ethnic differences in occurrence of medical factors per 1000 live births, per 1000 fetal deaths, and fetal deaths per 1000 pregnancies with that factor, Texas births, 1993 through 1995.

	Occurrence						Fetal Mortality Rate Per 1000*		
	Per 1000 Live Births			Per 1000 Fetal Deaths					
Risk Factor	White	Black	Hispanic	White	Black	Hispanic	White	Black	Hispanic
Anemia	24.78	**41.73**	25.17	28.06	**57.07**	30.07	6.42	**13.53**	6.99
Cardiac disease	**4.71**	2.46	1.32	4.61	6.62	1.69	5.54	**26.32**	7.51
Acute/chronic lung disease	6.28	5.43	2.16	**12.14**	7.44	4.66	10.92	13.58	12.53
Diabetes	26.62	21.35	28.67	27.22	34.74	49.98	5.80	16.06	10.17
Hydramnios/oligohydramnios	8.70	9.72	8.09	61.98	33.09	50.40	39.05	33.00	35.44
Hemoglobinopathy	0.31	**1.44**	0.21	2.51	3.31	0.0	**44.44**	22.47	0.0
Hypertension, chronic	7.43	**11.49**	3.34	25.54	**43.01**	18.64	19.24	36.19	31.84
Hypertension, pregnancy associated	43.47	44.43	30.94	52.35	60.38	43.63	6.82	**13.45**	8.24
Eclampsia	3.13	3.23	3.42	2.51	9.93	5.51	4.56	**29.93**	9.41
Incompetent cervix	2.16	2.97	0.90	30.99	38.88	22.03	75.82	116.05	125.60
Previous birth, > 4 kg	**13.09**	3.69	6.26	8.38	5.79	8.05	3.64	**15.49**	7.53
Previous preterm, SGA	8.39	10.84	4.96	31.41	29.78	25.41	20.92	26.81	29.34
Renal disease	2.22	1.63	3.03	6.70	3.31	4.66	16.97	20.00	8.99
Rh isoimmunization	**8.64**	2.55	2.06	**8.38**	3.31	5.51	5.50	12.86	15.50
PROM	18.58	25.79	13.48	95.48	100.91	80.05	28.48	37.76	33.77
Sexually transmitted diseases	21.20	**47.88**	13.73	13.82	**56.25**	16.52	3.71	**11.64**	7.04
Other	121.64	139.60	100.53	224.46	216.71	182.50	10.42	15.33	10.59
None	715.75	687.28	770.65	443.89	383.79	441.61	3.53	**5.57**	3.37
Unknown	20.79	18.57	20.54	98.41	121.59	161.37	26.29	61.64	44.25

SGA = small for gestational age
PROM = premature rupture of membranes

* Fetal deaths associated with a maternal medical factor per 1000 live births plus fetal deaths associated with the factor.

Boldfaced values for 1 ethnic group are at least 1.5 times those of both other ethnic groups.

tion of fetal deaths was not realized, largely because these causes are either too nonspecific (as with "unspecified conditions originating in the perinatal period") or because they offer few preventive options (as with abruptio placenta, lethal congenital anomalies, and extreme preterm birth).

The ethnic differences in fetal deaths associated with the medical risk factors are intriguing. The higher rates of anemia, hemoglobinopathy, and hypertension in pregnancies of black women could be anticipated, but a recent review (24) concluded that black women are at greater risk than white women for 12 of 16 identified risk factors for fetal death, and this increased risk is largely unexplained.

The ethnic differences might reflect differences in pathophysiologic processes, but they also could represent small numbers or differences in reporting, and birth records are notorious for their incompleteness (12,24,33–35). Also, a factor might be scrutinized more closely when associated with a fetal death than when it was associated with an uneventful live birth. More worrisome, the ethnic differences may possibly reflect differences in prenatal care and in the early diagnosis and treatment of preventable and/or treatable risk factors for fetal death. The findings of the present exploration need to be confirmed and expanded by examination of the potentially contributory roles of other factors listed on fetal death certificates, such as substance abuse, maternal weight gain, and details of prenatal care. Together, they may eventually help explain the differences that appear to exist in pregnancy outcomes among the different ethnic populations in Texas.

As with the IMR, the FMR in Texas has been decreasing over the past decades, from 3767 fetal deaths and a fetal mortality ratio (fetal deaths per 1000 live births) of 15.3 in 1960 to 1964 fetal deaths and a fetal mortality ratio of 5.9 in 1996 (2). The reason for the decline is not clear, although identification and treatment of potentially lethal complications of pregnancy, together with improved prenatal care, surely played important contributory roles. The main conclusion from this study is that few of the underlying causes reported for fetal death in Texas are open to primary preventive strategies. The most logical preventive focus

at present would appear to be closer surveillance and care of women with demographic, reproductive, and medical factors associated with increased risk of fetal death.

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Live Oak Cancer Center
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(210) 599-0922; Fax (210) 599-0982

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Diseases and Surgery of the Eye

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Orthopaedic Surgery-Oncology
Metastatic Bone Disease
Limb Salvage Surgery
Osteomyelitis
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(817) 335-4316
http://home.swbell.net/fracture

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Medical City Dallas II, 7777 Forest Lane, Suite B116
Dallas, Texas 75230; (972) 556-7010

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Classified Directory

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Community Medicine Associates, Inc. (CMA) is a not-for-profit physician organization sponsored by the University Health System, presently staffing four community health centers in San Antonio, Texas. CMA is currently seeking board-eligible or certified Family Physicians to provide comprehensive primary care services to residents of Bexar County. Two sites presently have Family Practice residents and a small percentage of time will be spent supervising these residents.

The practice is strictly based in ambulatory clinics. Physicians will enjoy a forty-hour work week, light on-call duty (by phone only) with evening and Saturday clinic hours an average of one to four times per month.

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Attn: A. Casas, Human Resources
4502 Medical Drive
San Antonio, Texas 78229
Email: acasas@university-health-sys.com
Fax: (210) 358-4765

Family/General Practice

FAMILY MEDICINE

The University of Texas Medical Branch Conroe Family Medicine Residency Program needs an experienced board certified family medicine faculty member (non tenure track, clinical). Experience should include obstetrics, teaching, and a minimum of two years practice experience. Must have a Texas license. Our program is accredited and has 21 residents. Conroe is a beautiful suburban community located only 40 miles north of Houston. UTMB is an EO/AA employer M/F/D/V. UTMB is a smoke free/drug free workplace. UTMB hires only individuals authorized to work in the United States.

Please respond by contacting
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University of Texas Medical Branch,
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Residency Program Director. The University of Texas Medical Branch at Galveston is seeking a board certified family physician to serve as Residency Program Director for the St. Mary/St. Elizabeth Family Practice Program's ACGME accredited community based Family Practice Residency. This 10-10-10 residency is located in Port Arthur/Beaumont, TX and is affiliated with the Medical Branch. Applicants must have demonstrated ability as a teacher and clinician and have administrative experience. Experience as a Residency Program Director or Associate Residency Program Director is highly desirable. The Program Director will hold a faculty appointment with UTMB. Responsibilities will include: 1) Recruitment of suitable applicants to the program; 2) Development of curriculum and experiences within the guidelines of the Accreditation Council for Graduate Medical Education, Family Practice Residency Review Committee; 3) Provide for the long-term growth and stability of the Program. Port Arthur/Beaumont is known for its year-round outdoor recreation, which includes fishing, golf, bird watching, hunting, etc. It is home to Lamar University, a major four-year institution and is one hour from Houston, TX and four hours from New Orleans, LA. Applicants may submit curriculum vitae and a list of references to: Mr. Marshall Kratz, Search Committee Chairman, 830 North 11th Street, Beaumont, TX 77702. UTMB is an EO/AA employer, M/F/D/V. UTMB is a smoke free/drug free work place. UTMB hires only individuals authorized to work in the United States.

Austin, Texas—Medical Director/Primary Care Physician. Employed position available immediately with well established primary/urgent care clinic-based practices. Board certified family practice physician preferred, but will consider board certified internal medicine/ER physician. 40% medical director time involves managing medical policies, medical staffing, practitioner meetings, oversight of laboratory operations, and other administrative duties related to clinic operations. 60% clinic time seeing patients. M-F schedule. Salary and benefits. J-1 visa not available. Please send your CV to: Brennan McNally, PO Box 1788, Austin, Texas 78767-1788; or fax to (512) 482-4167.

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Open Rank: BC/BE Internist. Baylor College of Medicine-Houston. Faculty position for internist with an interest in Emergency Medicine and urgent care for July 1, 2000. Responsibilities include patient care, housestaff supervision, teaching, and administrative responsibilities. Clinical research is encouraged. Send CV and letter of interest to J. L. Zimmerman, MD, 1504 Taub Loop, Houston, Texas 77030. Fax (713) 799-1917. Baylor College of Medicine is an affirmative action, equal opportunity, equal access employer.

General Internist Needed for North Texas area. Salary and benefits negotiable. Immediate start preferred. Two year contract with future ownership possibilities. No capitation in area. Send CV to 1722 Ninth Street, Wichita Falls, TX 76301, or call (940) 716-1656.

TEXAS—Major University Town. New! Outstanding opportunity for Internist in popular, major university town serving over 250,000 population. Nice facilities. Call coverage. Attractive financial package with above average potential. Airport serving major airlines. Access to major metro cities. Contact: Mark Hall, THE TEXAS RECRUITERS, (888) 844-TEXAS. Fax (903) 677-6795. mhall@txrecruiters.com.

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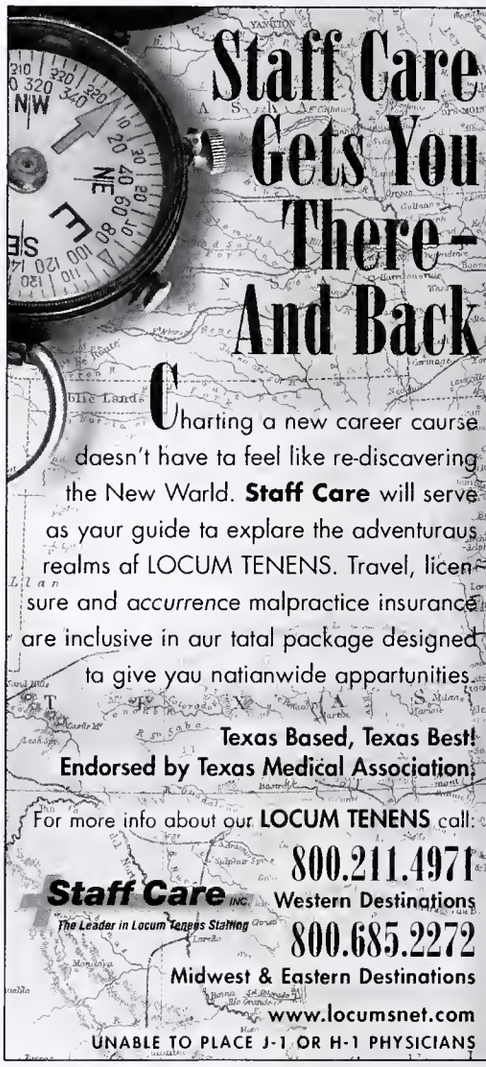

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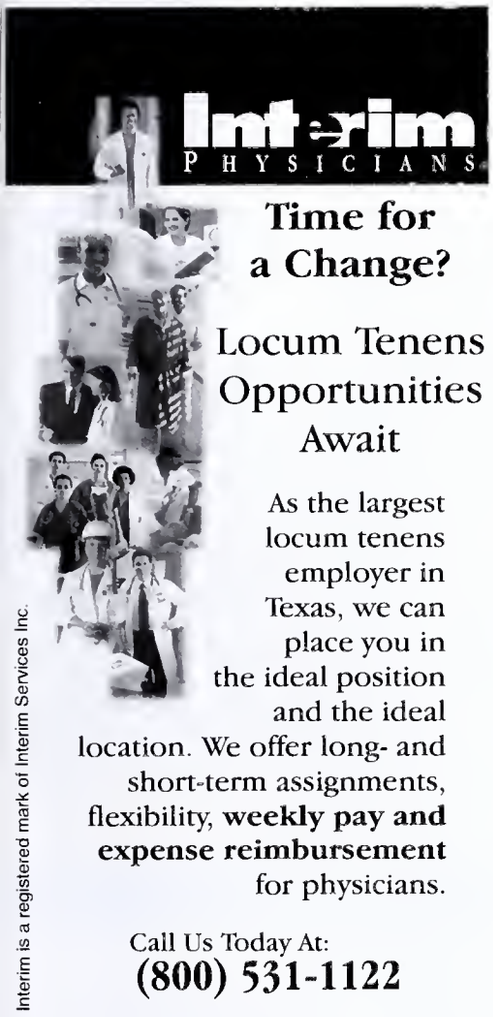

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Medical Director (Houston, TX). Dynamic health care delivery system is seeking a highly motivated medical director. The candidate will have demonstrable, organizational, communication and political skills. The position requires experience in HMO medical management, including UM, credentialing, quality improvement, and case management. A background in Medicaid is desirable. For additional information please contact Leroy A. Miller, MD, (858) 492-4422 or (800) 377-2055.

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TEXAS MEDICINE CLASSIFIED DIRECTORY DEADLINES

ISSUE	DEADLINE
February 2000	**Dec. 31, 1999**
March 2000	**Feb. 1, 2000**
April 2000	**March 1, 2000**

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Advanced Emergency Medicine	Feb. 18-19
Echocardiography	Jan. 24-31
Endovaginal Ultrasound	Dec. 10-11
Abdominal Doppler	Jan. 15
Emergency Medicine	Jan. 6-8
Intro to PV	Dec. 3-4
Abdominal (5 Day)	Jan. 10-14
OB/GYN (5 Day)	Dec. 6-10
Vascular	Dec. 13-17
Family Practice Physicians	Feb. 3-5

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Program Director: Edwyn L. Boyd, MD

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Call (281) 955-3720

Southwestern Center for Minimally Invasive Surgery: Comprehensive Gynecologic Laparoscopy, Dec. 10-11 in Dallas. Course includes live surgery and/or video session, hands-on videotrainer workshop and an in vivo laboratory. Sponsored by The University of Texas Southwestern Medical Center at Dallas, Department of OB/GYN. Director: R. Coleman, MD. CME credit offered. Contact: Leah Cannon, (214) 648-3792.

The Alliance for Medical Management Education Degree and Certificate Program—Healthcare Financial Management, Jan. 9-14 and Managing Change in Healthcare Feb. 2-11 at North Dallas Renaissance Hotel. The University of Texas Southwestern Medical Center at Dallas jointly sponsored with The University of Texas at Dallas. Directors: J. Burnside, MD; J. McCracken, PhD. CME and graduate academic credit offered. Contact: Paul Krawietz, (214) 648-3705.

Southwestern Center for Minimally Invasive Surgery: Surgical Education, Jan. 14 in Dallas. An introduction to surgical education for young academic surgeons who are interested in surgical education as part of their career path. Sponsored by The University of Texas Southwestern Medical Center at Dallas, Department of Surgery. Director: P. Bergen, MD. CME credit offered. Contact: Leah Cannon, (214) 648-3792.

Lymphatic Mapping and Sentinel Lymph Node Biopsy in Breast Cancer and Melanoma, Jan. 20 in Dallas. Course includes live surgery broadcast and hands-on in vivo laboratory. Sponsored by The University of Texas Southwestern Medical Center at Dallas, Department of Surgery, Division of Surgical Oncology. Directors: T. Anthony, MD; W. Erdman, MD; D. Euhus, MD; D. Matthews, MD, PhD. CME Credit offered. Contact: (214) 648-3138.

Southwestern Center for Minimally Invasive Surgery: Minimally Invasive Surgery Nursing Update, Jan. 22 in Dallas. Sponsored by The University of Texas Southwestern Medical Center at Dallas, Department of Surgery. Director: S. Tesfay, RN. Credit offered. Contact: (214) 648-3138.

Southwestern Center for Minimally Invasive Surgery: GERD—Medical and Laparoscopic Advances, Feb. 24-25 in Dallas. Course includes didactic sessions on the treatment of gastroesophageal reflux disease, live telesurgery, instructional workshops and wet labs. Sponsored by The University of Texas Southwestern Medical Center at Dallas, Departments of Internal medicine and Surgery. Directors: S. Burdick, MD; D. Jones, MD. CME credit offered. Contact: (214) 648-3138.

7th Annual Progress in Clinical Pathology, March 2-4 at Le Meridien Hotel, Dallas. Sponsored by The University of Texas Southwestern Medical Center at Dallas, Department of Pathology. Director: R. McKenna, MD. CME credit offered. Contact: Jim O'Reilly, (214) 648-3794.

Call TMA at (800) 880-1300 or (512) 370-1300 for details.

December 1999

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TMA Planner

February 24–26, 2000
TMA Winter Conference: Medicine's Relevance in the 21st Century
Renaissance Austin Hotel

May 25–28, 2000
TexMed 2000
River Center and Convention Center
San Antonio

September 14–16, 2000
TMA Fall Conference: Policy and Leadership Development
Renaissance Austin Hotel

December 1999

December 1	Corpus Christi	Medical Records Dos, Don'ts, and Other Intriguing Dilemmas
December 2	San Antonio	Policy and Procedure II: Employment Issues and Office Safety
December 3	Tyler	Oral Health in Cancer Therapy
December 6	Victoria	Genetic Evaluation for Cancer
December 8	Texarkana	Physician Stress and Burnout
December 9	Tyler	Policy and Procedure II: Employment Issues and Office Safety
December 16	Abilene	Policy and Procedure II: Employment Issues and Office Safety
December 20	Fort Worth	Physician Stress and Burnout

January 2000

January 21–22	Austin	TEXPAC Retreat
January 29	Corpus Christi	7th Annual Physician Health and Rehabilitation Retreat

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